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SECTION I - INTRODUCTION

A. INTRODUCTION

This new edition of the Kentucky Medicaid Program Adult Day Health Care Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, 275 East Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, 275 East Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 756-7557 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAID

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department shall not reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age. The Kentucky Medicaid Program serves eligible recipients of all ages.

SECTION II - KENTUCKY MEDICAID

B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

SECTION II - KENTUCKY MEDICAID

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Program have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement from such third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount should be made to Medicaid, as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.

SECTION II - KENTUCKY MEDICAID

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department make payment for a covered services and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

SECTION II - KENTUCKY MEDICAID

All services are reviewed for recipients and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medicaid Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
- (3) having knowledge of the occurrence of any event affecting
 - (A) his initial or continued right to any such benefit or payment, or
 - (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

SECTION II - KENTUCKY MEDICAID

- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

SECTION II - KENTUCKY MEDICAID

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

- (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
 - (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (3) Paragraphs (1) and (2) shall not apply to--
- (A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and
 - (B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.
- (c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

SECTION II - KENTUCKY MEDICAID

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Definition of Adult Day Health Care

Adult Day Health Care is a program of services provided under health leadership in an ambulatory care setting for adults who due to physical or mental impairment, are not capable of full time independent living. Participants in the Adult Day Health Care Program must meet all eligibility requirements under the Home and Community Based Services Waiver and be referred to the Adult Day Health Care Program by the Home and Community Based Services Provider and their attending physician. The essential elements of a day health care program are directed toward meeting the health maintenance and restoration needs of the recipient. However, there are socialization elements in the program which relate to the isolation so often associated with illness in the aged and disabled, and which are considered vital for the purpose of fostering and maintaining the maximum possible state of health and well being.

Licensed Adult Day Health Care Centers, including long term care facilities which are appropriately licensed in Kentucky for the provision of adult day health care services, may be certified for participation in the Medicaid. The Center must have obtained a certificate of need, from the Commission for Health Economics Control and have met the requirements for licensure as Adult Day Health Care services. Participating centers shall required to meet all applicable federal, state, and local requirements.

B. Application for Participation

In order to participate in the Home and Community Based Services Program as a provider of adult day health care, the center must complete an application to participate which includes:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344)

SECTION III - CONDITIONS OF PARTICIPATION

Additionally, the Adult Day Health Care Center must submit a verification of current license. Both copies of the MAP-343, the MAP-344, a Statement related to services and charges, and the license verification, are to be submitted to:

Division of Program Services
ATTN: Provider Enrollment
Department for Medicaid Services
Cabinet for Human Resources
275 East Main Street
Frankfort, KY 40621

The yellow copy of the Application for Participation (MAP-343), will be returned to the center along with a cover letter indicating the provider number and effective date of participation. Questions regarding enrollment may be addressed to Provider Enrollment, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621 or Phone (502) 564-3476.

Services must be furnished by the participating Adult Day Health Care Center or by others under approved contractual arrangements with the Center. Only those arrangements or contracts made by the Adult Day Health Care Center with another health organization or individual approved by the Division of Licensing and Regulations will be acceptable by Medicaid. Arrangements made by an Adult Day Health Care Center with others to provide services must be stipulated in such a way that receipt of payment by the Adult Day Health Care Center for the service (whether in its own right or as an agent) discharges the liability of the recipient or Medicaid to make any additional payment for such services.

C. The Home-and Community-Based Program and Provision of Adult Day Health Care Services as a Part of that Program

Adult Day Health Care Services are only covered as a part of the Home-and Community-Based (HCB) Program. HCB Program services provided by Medicaid certified HCB Program providers shall be payable by the Medicaid Program, when provided to Medicaid recipients who have

SECTION III - CONDITIONS OF PARTICIPATION

been determined by the Professional Review Organization (PRO) to meet the level of care for Nursing Facility services, and have been prior authorized by the Department for Medicaid Services to receive HCB Program Services. The physician shall order the services and certify that if waiver services were not available, he would order Nursing Facility services, and the individual would be admitted in the immediate future.

It shall be the responsibility of the Home-and Community-Based (HCB) provider to initiate the assessment and certification process to determine whether the recipient is eligible to receive HCB services including Adult Day Health Care. The HCB provider shall:

1. Obtain the physician's orders for services and certification regarding need for nursing facility level of care,
2. Obtain the level of care determination by the professional review organization, and
3. Obtain prior authorization to provide the HCB services from the Department for Medicaid Services.

The HCB provider shall be responsible for providing all HCB recipients at least one case management contact per month (every 30-31 days) to assess the service delivery. This contact may be by telephone or face-to-face. However, a face-to-face contact with the recipient shall be made at least every other month. The face-to-face contact with the adult day health care recipient may be made while the recipient is at the adult day health care center.

The HCB provider shall provide reassessment and recertification regarding the continuing need for HCB services at least every six (6) months. The same general procedures used for the initial assessment apply to the reassessment. Medicaid reimbursement shall not be available for any waiver service (including Adult Day Health Care) provided during any period of time that the recipient is not covered by a valid Level of Care Certification or has not been reassessed and prior authorized. Additionally, if more than sixty (60) days have elapsed since the end of the previous certification period, the recipient will be considered terminated from the HCB Program.

It shall also be the responsibility of the Adult Day Health Care provider to assure that all HCB recipients receiving Adult Day

SECTION III - CONDITIONS OF PARTICIPATION

Health Care Services have been appropriately reassessed and recertified.

Although the HCB provider shall arrange for the provision of the Adult Day Health Care Services the HCB provider shall develop its own plan of treatment for the services provided to the recipient in accordance with the care need findings of the comprehensive assessment and the physician's orders. (Information obtained through the initial assessment shall be used in conjunction with any additional information.)

Reimbursement shall be made directly to the adult day health care provider for Adult Day Health Care Services provided by the Center.

Adult Day Health Care Services are to be furnished to Medicaid recipients eligible under the Waiver by members of the health team in the adult day health care center. The health team should include but not be limited to the following: Physician, Registered Nurse, Activities Director, Physical Therapist, Speech Pathologist, Social Worker, Nutritionist, Health Aide, and Occupational Therapist (if available).

1. Plan of Treatment

Adult Day Health Care Services are provided to Medicaid recipients eligible under the waiver in accordance with a physician's plan of treatment for Adult Day Health Care Services.

The plan of treatment developed by the physician in consultation with appropriate agency staff shall cover all pertinent diagnoses, mental status, types of services required, frequency of visits to the center, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Any additions or modifications to the original plan of treatment are to be indicated on a change of order form, signed by the physician and included in the recertification. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency and duration of such therapy service. Individual plans would need to be developed for therapy services.

SECTION III - CONDITIONS OF PARTICIPATION

- a. CONFORMANCE WITH PHYSICIAN'S ORDERS: Drugs and treatments are administered by Center staff only as ordered by the physician. The nurse or therapist shall immediately record and sign oral orders and obtain the physician's countersignature as soon as possible. Center staff shall evaluate and monitor all patient medications for possible adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.
- b. REVIEW OF PLAN OF TREATMENT: The total plan of treatment shall be reviewed by the recipient's physician and Center personnel as often as every 90 days. Included in the review of the plan of care shall be the physician's certification or recertification of the need for continued care.

Responsibility for assuring that the Adult Day Health Care Services continue to maintain the recipient at the maximum level possible will be assumed by the physician and the Health Team. Evaluations should be made at the time of recertification, or earlier, if the severity of the recipient's illness indicates the need for institutionalization or another type of care.

Should a recipient's condition become such that a different type of care would be more beneficial, the Center staff shall make the necessary transfer or referral and advise the Home and Community Based Services Provider of such referral or transfer. The Home and Community Based Services Provider shall notify the Department for Medicaid Services.

SECTION III - CONDITIONS OF PARTICIPATION

D. Termination of Provider Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;
3. Misrepresenting factors concerning a facility's qualifications as a provider;
4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or
5. Submitting false or questionable charges to the agency.

SECTION III - CONDITIONS OF PARTICIPATION

The Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;
2. The effective date;
3. The extent of its applicability to participation in the Medicaid Program;
4. The earliest date on which the Cabinet will accept a request for reinstatement;
5. The requirements and procedures for reinstatement; and
6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
3. Counsel representing the provider;

SECTION III - CONDITIONS OF PARTICIPATION

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or nonrenewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

E. Change of Ownership

The Adult Day Health Care Provider shall complete new participation agreement forms whenever the agency has a change of ownership. The information and forms necessary to complete the application to participate in the Medicaid are:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344); and
3. Verification of current Adult Day Health Care license.

These forms shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency, the name of the new agency and the effective date of the change.

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F. Disclosure of Information (42 CFR 405, 420, 413 and 455)

There are some requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act.) The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). The portions applicable to Medicaid are outlined for you. The regulations are significant and we suggest your attention to them.

Of particular impact on Medicaid providers are the following:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX, or XX.
2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.
3. The Secretary may have access to Medicaid provider records.
4. Providers are required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

G. Withdrawal of Participation

If a provider withdraws participation in Medicaid, written notice shall be given to the Cabinet for Human Resources, Department for Medicaid Services at least thirty (30) days prior to the effective date of withdrawal. Payment may not be made for services or items provided to recipients on or after the effective date of withdrawal.

SECTION III - CONDITIONS OF PARTICIPATION

H. Patient Consent Forms

Please be advised that neither the Office of Inspector General (Licensing and Regulation or Audits) nor Medicaid personnel are required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid Program.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare shall be appealed through Medicare procedures.

I. Medical Records

Medical records shall substantiate the services billed to Medicaid by the Home Health Agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

Medical records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

SECTION IV - COVERED SERVICES

IV. COVERED SERVICES

A. Basic Services

Adult Day Health Care Service coverage shall include reimbursement for basic and certain ancillary services.

Basic services shall include:

1. One meal per day including special diets;
2. Snacks, as appropriate;
3. R.N. and other supervision;
4. Regularly scheduled daily activities
5. Routine services required to meet daily personal and health care needs;
6. Equipment essential to the provision of adult day health care services; and
7. Incidental supplies necessary to provide adult day health care services.

B. Ancillary Services

The following ancillary services are included as covered services through the Adult Day Health Care element of Medicaid, when provided to a recipient eligible under the Waiver in an Adult Day Health Care Center and ordered by a physician in a plan of treatment:

As appropriate, physical, occupational, or speech therapy may be provided as ancillary services by the adult day health care center under contractual arrangement with a qualified therapist in accordance with the plan of treatment. It is expected that generally these services shall consist of evaluations (reevaluations), for the purpose of developing a plan which could be carried out by the recipient or Adult Day Health Care Center staff. However, individualized therapy services provided by the therapist to a recipient in accordance with the plan of treatment may be covered as ancillary services. The qualified therapist assists the physician in evaluating the level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with other center personnel and participates in inservice programs.

1. Physical therapy shall include such services as:

SECTION IV - COVERED SERVICES

- a. Assisting the physician to evaluate the recipient for physical therapy through the application of muscle, nerve, joint and functional ability tests.
- b. Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion.
- c. Gait evaluation and training.
- d. Transfer training and instructions in care and use of wheelchairs, braces, and prosthesis, etc.
- e. Instruction in breathing exercises, percussion, postural drainage, vibration for pulmonary functioning.
- f. Teaching compensatory technique to improve the level of independence in activities of daily living.
- g. Training and instructions for recipient or center staff in setting up and following a physical therapy program.

Standard:

The physical therapist shall be qualified and appropriately licensed by the State of Kentucky as a physical therapist.

SECTION IV - COVERED SERVICES

Specific Guidelines:

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of procedures which could be safely and effectively provided by the recipient or Center staff.

2. Occupational therapy shall include such services as:
 - a. Assisting the physician to evaluate the recipient for occupational therapy services through the appropriate testing technique.
 - b. Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion.
 - c. Assisting the recipient to obtain better coordination, use of senses and perception.
 - d. Instructing the recipient or adult day health care center staff in setting up and following an occupational therapy program.
 - e. Teaching compensatory technique to improve the level of independence in activities of daily living.
 - f. Designing and fitting orthotic and self-help devices (i.e., hand splints for the patient with rheumatoid arthritis).

Standard:

The occupational therapist shall be qualified as an occupational therapist and registered by the American Occupational Therapy Association.

SECTION IV - COVERED SERVICES

Specific Guidelines:

The services shall be reasonable and necessary for the recipient's condition and must be of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of procedures which could be safely and effectively provided by the recipient or center staff.

3. Speech pathology shall include such services as:
 - a. Assisting the physician to evaluate the recipient for speech pathology service through the appropriate testing techniques.
 - b. Determining and recommending appropriate speech and hearing services.
 - c. Providing necessary rehabilitative services for recipient with speech, hearing, or language disabilities.
 - d. Instructions for the recipient or adult day health care center staff in setting up and following a speech pathology program.

Standard:

The speech pathologist shall be qualified and appropriately licensed by the State of Kentucky as a speech pathologist.

Specific Guidelines:

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of simple procedures which could be safely and effectively provided by the recipient or center staff.

SECTION IV - COVERED SERVICES

C. Non-Covered Services

Examples of services not covered under the Adult Day Health Care element are as follows:

1. The Medicaid recipient did not meet level of care for the waiver.
2. Transportation is not covered under this service element, but is a separately reimbursable service pursuant to 907 KAR 1:060, Medical Transportation.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

Reimbursement for Adult Day Health Care Services shall be paid directly to the licensed participating Adult Day Health Care Center on the basis of an interim rate with a year-end cost settlement to the lower of actual reasonable allowable costs or charges. The basic rate shall not exceed eighty (80) percent of the maximum Medicaid intermediate care reimbursement rate for routine services. Reimbursement for ancillary services shall not exceed eighty (80) percent of the approved maximum reimbursement rate for therapy services under the Medicaid home health program element.

A separate reimbursement manual has been developed to outline the Principles of Reimbursement for Adult Day Health Care Services. Please refer to the Adult Day Health Care Reimbursement Manual.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

VI. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, it shall be determined if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating vendors shall submit billings for medical services to a third party when such vendor has prior knowledge that such third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- If the recipient is a minor, ask about insurance the MOTHER, FATHER or GUARDIAN may carry on the recipient;
- In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- For people over 65 or disabled, seek a MEDICARE HIC number;
- Ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding insurance.

Following is a list of the insurance codes on the MAID card:

- A - Part A, Medicare only
- B - Part B, Medicare only
- C - Both parts A and B Medicare
- D - Blue Cross, Blue Shield
- E - Blue Cross, Blue Shield, Major Medical
- F - Private medical insurance
- G - Champus
- H - Health Maintenance Organization
- J - Other or unknown
- L - Absent Parent's insurance
- M - None
- N - United Mine Workers
- P - Black Lung

C. Billing Instructions for Claims Involving Third Party Resources

If the patient has third party resources that will pay for Adult Day Health Care Services, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

Exceptions:

*If the other insurance company has not responded within 120 days of the date of filing a claim to the insurance company, the provider shall submit a claim to EDS in the usual manner with a completed Third Party Liability (TPL) Lead Form attached which states, no response over 120 days. The EDS Third Party Liability Unit will verify coverage with the insurance company, update the recipient's file, if necessary, and bill the third party, if appropriate.

*If proof of denial for the same recipient for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial shall not be more than six months old.

*A letter from the provider indicating that he contacted XYZ insurance company and spoke with an agent to verify that the recipients was not covered, may also be attached to the Medicaid claim.

D. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for the Kentucky Medicaid Program payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider shall pursue payment with this third party resource before billing Medicaid again.

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 756-7557.

E. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained; the name of attorneys, other involved parties and the recipient's employer to the claim when submitting to EDS for Medicaid payment.

SECTION VII - COMPLETION OF THE INVOICE FORM

VII. COMPLETION OF THE INVOICE FORM

A. General Information

The Health Insurance Claim Form, HCFA-1500 (12-90), shall be used to bill for services rendered by Adult Day Health Care Centers to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

The original of the two part invoice set should be submitted to EDS as soon as possible after service is provided. The yellow copy of the invoice should be retained by the provider's office as a record of claim submittal.

Invoices should be mailed to:

E.D.S.
P.O. Box 2018
Frankfort, Kentucky 40602

1. General Billing Instructions

- a. The Health Insurance Claim Form, HCFA-1500 (12-90), shall be used in billing for all covered Adult Day Health Care Services rendered to Medicaid recipients eligible under the Waiver.
- b. The Health Insurance Claim Form, HCFA-1500 (12-90), shall be submitted at least monthly. It is emphasized that prompt and regular billing will be beneficial to the center as there would be less chance of the center receiving retroactive denials covering several months.

SECTION VII - COMPLETION OF THE INVOICE FORM

- c. Claims for covered services must be received by EDS within twelve (12) months from the date of service. Claims for covered services shall be received by EDS within 12 months from the date of service. Claims with service dates greater than twelve (12) months can only be processed with appropriate documentation such as one or more of the following: Remittance Statements no more than 12 months of age which verify timely filing; backdated MAID cards with "Backdated Card" written on the attached claim; Social Security documents; correspondence describing extenuating circumstances; Action Sheets, Return to Provider Letters; Medicare Explanation of Medical Benefits, etc.
- d. A separate billing statement shall be used for each recipient.
- e. A separate line must be completed for each day of service.
- f. A separate line must be completed when billing for covered ancillary services. The services should be entered singularly according to type of service. Please refer to the HCPCS procedure code list for ancillary services (Appendix V).

SECTION VII - COMPLETION OF THE INVOICE FORM

B. Procedural Coding

On May 1, 1985, Kentucky Medicaid adopted, for procedural coding purposes, the HCFA Common Procedure Coding System (HCPCS). Refer to Appendix V for procedure codes.

C. Completion of the Health Insurance Claim Form, HCFA-1500 (12-90),

An example of the Health Insurance Claim Form, HCFA-1500 (12-90), may be found in Appendix VI. Instructions for the proper completion of this form are presented below.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. The Medicaid Program cannot make payment for services rendered to an ineligible person.

SECTION VII - COMPLETION OF THE INVOICE FORM

BLOCK NO.	ITEM NAME AND DESCRIPTION
2	<p>Patient's name (Last Name, First Name, Middle Initial)</p> <p>Enter the recipient's last name, first name, middle initial, if any, exactly as it appears on the Medical Assistance Identification (MAID) card.</p>
9A	<p>Other Insured's Policy or Group Number</p> <p>Enter the recipient's ten (10) digit Medical Assistance Identification Number (MAID) exactly as it appears on the recipient's MAID card.</p> <p>IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the recipient's name appears on the card as an eligible recipient and that the card is valid for the period of time in which the services are to be provided. You SHALL NOT be paid services provided to an ineligible person.</p>
10	<p>Patient's Condition</p> <p>If the recipient's condition is related to employment, auto accident, or other accident, check the appropriate block.</p>
11	<p>Insured's Policy Group or FECA Number</p> <p>If the recipient has insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim enter the policy number of the other insurance.</p>
11C	<p>Insurance Plan Name or Program Name</p> <p>If the recipient has insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim enter the name of the other insurance company.</p>

SECTION VII - COMPLETION OF THE INVOICE FORM

- 21 Diagnosis or Nature of Illness or Injury
Enter the required appropriate ICD-9-CM diagnosis code.
- 24 Date(s) of Service
Enter the date the service(s) was provided in month, day, year
numeric format, for example, 03-02-92.
- 24B Enter the appropriate two (2) digit place of service which iden-
tifies the location where the service was provided to the recip-
ient. The place of service code for adult day health care ser-
vice is 99.
- 24D Procedures, Services, or Supplies
CPT/HCPCS
Enter the appropriate procedure code identifying the service or
supply provided to the recipient.
- 24E Diagnosis Code
Enter "1", "2", "3", "4" referencing the diagnosis for which
the recipient is being treated as indicated in block 21.
- 24F Charges
Enter the usual and customary charge for each service being
provided to the recipient.
- 24G Days or Units
Enter the number of units provided for the recipient on this
date if service. If the recipient was present in the center
for one-half day enter a 1. If the recipient was present in
the center for a whole day, enter a 2. Enter the unit for the
ancillary service.

SECTION VII - COMPLETION OF THE INVOICE FORM

- 24H EPSDT Family Plan
- Enter a "Y" if the treatment provided was a direct result of an Early Periodic Screening Diagnostic and Treatment examination.
- 26 Patient's Account No.
- Enter the patient account number, if desired. EDS will key the first seven (7) or fewer digits. This number appears on the remittance statement as the invoice number.
- 28 Total Charge
- Enter the total of all individual charges entered in column 24F.
- 29 Amount Paid
- Enter the amount paid, if any, by a private insurance. DO NOT ENTER MEDICARE PAID AMOUNT.
- 30 Balance Due
- REQUIRED ONLY IF A PRIVATE INSURANCE MADE PAYMENT ON THE CLAIM. Subtract the private insurance payment entered in field 29 from the total charge entered in field 28, and enter the net balance due in field 30.
- 31 SIGNATURE OF PHYSICIAN OF SUPPLIER INCLUDING DEGREES OR CREDENTIALS
- The actual signature of the provider (not a facsimile) or the provider's duly appointed representative is required. Stamped signatures are not acceptable.
- Date
- Enter the date the claim is submitted in a month, day, year numeric format, such as 03-21-92. This date must be on or after the date(s) of service billed on the claim.

SECTION VII - COMPLETION OF THE INVOICE FORM

33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND
 PHONE NUMBER

Enter the provider's name, address, zip code, and phone number.

PIN #

Enter the eight (8) digit individual Kentucky Medicaid provider number.

D. Billing Instructions for Claims with Service Dates Over one (1) Year
 Old

Medicaid claims shall be filed within one year of the date of service. Medicaid and Medicare crossovers shall be filed within one year of the date of service OR within six months of the Medicare Paid Date, whichever is longer. To process claims beyond this limit you shall attach, to EACH claim form involved, a copy of an in-process or denied claim remittance, no more than 12 months of age, which verifies that the original claim was submitted within 12 months of the service date.

Copies of previously submitted claim forms, providers' in-house records of claim submittal, letters which merely detail filing dates are NOT acceptable documentation of timely billing. Attachments must prove that the claim was RECEIVED timely by EDS.

If a claim is being submitted after twelve months from the date of service, due to the recipient's retroactive eligibility, a copy of the backdated or retroactive MAID card shall be attached to the invoice.

Please note on the claim the words "Backdated Eligibility" or "Retroactive Eligibility."

SECTION VII - COMPLETION OF THE INVOICE FORM

E. Electronic Media Claims

Electronic Media Claims (EMC) is a means by which Adult Day Health Care providers may submit claims electronically. EMC enables providers to experience an improved cash flow, fewer errors in claims processing, and a reduction in effort with claim preparation. Claims may be submitted electronically in a variety of different ways such as via magnetic tape, diskette, or modem.

Claims that require attachments shall not be submitted electronically.

For more information regarding EMC, contact an EMC Representative at (502) 227-9073 or 1-800-756-7557. You may also write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602.

SECTION VIII - REMITTANCE STATEMENT

VIII. REMITTANCE STATEMENT

A. General Information

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS Federal Corporation processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by Medicaid with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by Medicaid with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION VIII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix VII P.1. This section lists all those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR
ADULT DAY HEALTH CARE SERVICES

ITEM	DEFINITION
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS Federal Corporation.
CLAIM SVC DATE	The earliest and latest date of services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.
CHARGES NOT COVERED	Any portion of the provider's billed charges that are not being paid (examples: rejected line item, reduction in billed amount to allowed charge).

SECTION VIII - REMITTANCE STATEMENT

AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
LINE NO.	The number of the line on the claim being printed.
PS	Place of service code depicting the location of the rendered service.
PROC	The HCPCS procedure code in the line item.
QTY	The number of procedures/supply for that line item charge.
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item.
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item.
EOB	Explanation of benefit code which identifies the payment process used to pay the line item.

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix VII P.2.

All items printed have been previously defined in the description of the paid claims section of the Remittance Statement.

SECTION VIII - REMITTANCE STATEMENT

D. Section III - Claim in Process

The third section of the Remittance Statement (Appendix VII P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of date errors or the need for further review. A claim appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix VII P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/
DENIED

The total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.

AMOUNT PAID

The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.

SECTION VIII - REMITTANCE STATEMENT

WITHHELD AMOUNT	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies).
NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix VII P.5).

SECTION IX - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

TYPE OF INFORMATION REQUESTED	TIME FRAME FOR INQUIRY	MAILING ADDRESS
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Provider Relations
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Financial Services

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Inquiry	<ol style="list-style-type: none">1. Completed Inquiry Form2. Remittance Advice or Medicare EOMB, when applicable3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on a Remittance Advice within a reasonable amount of time

SECTION IX - GENERAL INFORMATION - EDS

TYPE OF
INFORMATION
REQUESTED

NECESSARY INFORMATION

Adjustment

1. Completed Adjustment Form
2. Corrected claim
3. Photocopy of the applicable portion of the Remittance Advice in question

Refund

1. Refund Check
2. Cash Refund Documentation Form
3. Photocopy of the applicable portion of the Remittance Advice in question
4. Reason for refund

B. Telephoned Inquiry Information

WHAT IS NEEDED?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

WHEN TO CALL?

- When claim is not showing on paid, pending or denied sections of the Remittance Advice within 6 weeks
- When the status of claims is needed and they do not exceed five in number

WHERE TO CALL?

- Toll-free number 1-800-756-7557 (within Kentucky)
- Local (502) 227-2525

SECTION IX - GENERAL INFORMATION - EDS

C. Filing Limitations

- | | |
|-------------------|----------------------------------|
| New Claims | - 12 months from date of service |
| Medicare/Medicaid | - 12 months from date of service |

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.

- | | |
|---------------------------------|----------------------------------|
| Third-Party
Liability Claims | - 12 months from date of service |
|---------------------------------|----------------------------------|

NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

- | | |
|-------------|---|
| Adjustments | - 12 months from date the paid claim appeared on the Remittance Advice. |
|-------------|---|

SECTION IX - GENERAL INFORMATION - EDS

D. Provider Inquiry Form

The Provider Inquiry Form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry Form should be completed for each status request.) The Provider Inquiry form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry Form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-800-756-7557 or 1-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry Form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT necessary to complete a Provider Inquiry Form when resubmitting a denied claim.

Provider Inquiry Forms may NOT be used in lieu of the Medicaid Claim Forms, Adjustment Forms, or any other document required by the Medicaid program.

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry Form are found on the next page.

SECTION IX - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry Form:

FIELD NUMBER	INSTRUCTIONS
1	Enter your 8-digit Kentucky Medicaid Provider Number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medicaid ID number.
5	Enter the billed amount of the claim on which you are inquiring.
6	Enter the claim service date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

SECTION X - GENERAL INFORMATION - EDS

the "Paid Claims" page of your Remittance Statement. (If several ICN's are to be applied to one check, they can be listed on the same form only if they have the same reason for refund explanation (see below).

REASON FOR REFUND

Check the appropriate reason for which the claim is being refunded. Be sure to complete all blanks. The example listed below shows how each refund is to be completed accurately. Only one reason can be completed per Cash Refund Documentation Form. If multiple claims with multiple refund reasons are included in one check, complete a separate form for each refund reason.

- a. Payment from other source - Check the category and list name (attach a copy of EOB)

Health Insurance	
Auto Insurance	
Medicare paid	
Other	Worker's Comp-ABC Construction
- b. Billed in error
- c. Duplicate payment (attach a copy of both Remittance Statement) If Remittance Statement are paid to 2 different providers specify to which provider number the check is to be applied

1	2	3	4	5	6	7	8
---	---	---	---	---	---	---	---
- d. Processing error or Overpayment

Explain why	Processing error-wrong date of service was keyed
-------------	--
- e. Paid to wrong provider
- f. Money has been requested - date of letter 1-1089 (Attach a copy of letter requesting money)

SECTION X - GENERAL INFORMATION - EDS

g. Other

Medicare made an adjustment. Deductible no longer due

Contact Name:

DEPARTMENT FOR MEDICAID SERVICES

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to recipients under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-second birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Examination
- Growth and Development Assessment
- Hearing, Dental, and Vision Screenings
- Lab tests as indicated
- Assessment or Updating of Immunizations

DEPARTMENT FOR MEDICAID SERVICES

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aide services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorized by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

OUTPATIENT SERVICES

Benefits of this Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

DEPARTMENT FOR MEDICAID SERVICES

LONG TERM CARE FACILITY SERVICES

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND
DEVELOPMENTALLY DISABLED (ICF/MR/DD)

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

- Outpatient Services
- Psychosocial Rehabilitation
- Emergency Services
- Inpatient Services
- Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up post partum visits within four (4) to six (6) weeks of the delivery date.

NURSE PRACTITIONER

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure.

DEPARTMENT FOR MEDICAID SERVICES

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed periodically with monthly updates. Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs, selected vaccines and Rhogam), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

DEPARTMENT FOR MEDICAID SERVICES

Limited coverage:

Certain types of office exams, such as comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional supervision.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment services must be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES

RENAL DIALYSIS CENTER SERVICES

Free-standing renal dialysis center service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

DEPARTMENT FOR MEDICAID SERVICES

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

****SPECIAL PROGRAMS****

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only shall be covered under KenPAC. The recipient shall choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

The Alternative Intermediate Services for the Mentally Retarded (AIS/MR) home-and community-based services project provides coverage for an array of community based services that shall be an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD).

DEPARTMENT FOR MEDICAID SERVICES

HOME AND COMMUNITY BASED WAIVER SERVICES

A home-and community-based services program provides Medicaid coverage for a broad array of home-and community-based services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. The services became available statewide effective July 1, 1987. These services shall be arranged for and provided by home health agencies.

SPECIAL HOME-AND COMMUNITY-BASED SERVICES MODEL WAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the program administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Person wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend-down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend-down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend-down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
* From* date is first day of eligibility of this card.
To date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance- Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	AGE
ELIGIBILITY PERIOD FROM: 06-01-88 TO: 07-01-88 CASE NUMBER 007 C 000123456		Smith, Jane Smith, KIm	1234567890 2345678912	2 2	0353	M
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601					1284	M
ISSUE DATE: 06-27-88 ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS <small>SEE OTHER SIDE FOR SIGNATURE MAP 000A REV 000</small>						

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P. Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-A
(cont.)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

This card certifies that the person(s) listed herein is/are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Champus |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulation, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipients temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 206.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf. Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance or fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

APPENDIX II-B

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
"From" date is first day of eligibility of this card.
"To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

NOTICE
QMB
Info.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD FROM: 08-01-88 TO: 07-01-89 CASE NUMBER 037 C 000123456		... THIS PERSON IS ALSO ELIGIBLE FOR QMB BENEFITS ...			
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane Smith, Kim	1234567890 2345678912	2 0353 2 1284	M M
ISSUE DATE: 05-27-88					
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS					
SEE OTHER SIDE FOR SIGNATURE					

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P.
Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-B
(cont.)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

This card certifies that the persons listed herein are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Charms |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and/or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 206.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf. Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance or fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(FRONT OF CARD)

Red

Blue

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Eligibility period is the month, day and year of QMB eligibility represented by this card.
* From* date is first day of eligibility of this card. *To* date is the day eligibility of this card ends and is not included as an eligible day.

Medical Insurance Code indicates type of insurance coverage.

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES
IDENTIFICATION CARD
COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES

ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO:
<p>Jane Smith 400 Block Ave. Frankfort, KY 40601</p>	FROM:	<p>★ MEDICARE PART B PREMIUMS</p> <p>★ MEDICARE CO-INSURANCE</p> <p>★ MEDICARE DEDUCTIBLES</p> <p>SEE REVERSE SIDE FOR ADDITIONAL INFORMATION</p>
	TO:	
	MEDICAID QMB ID. NO.	
	SEX CODE	
	INSURANCE ID.	
	DATE OF BIRTH MONTH/YEAR	
<p>ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE</p>		<p>PLEASE SIGN IMMEDIATELY</p>

MAP 520-C REV 11-88

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES														
<p>1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductibles only.</p> <p>2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p>Cabinet for Human Resources Department for Medicaid Services 275 East Main Street Frankfort, KY 40621-0001</p>	<p>1. Show this card whenever you receive medical care.</p> <p>2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.</p> <p>3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>4. If you have questions, contact your case worker at the Department for Social Insurance County office.</p>														
<p>Insurance Identification</p> <table><tbody><tr><td>A—Part A, Medicare Only</td><td>G—Champus</td></tr><tr><td>B—Part B, Medicare Only</td><td>H—Health Maintenance Organization</td></tr><tr><td>C—Both Parts A & B Medicare</td><td>J—Other and / or Unknown</td></tr><tr><td>D—Blue Cross /Blue Shield</td><td>L—Absent Parent's Insurance</td></tr><tr><td>E—Blue Cross /Blue Shield Major Medical</td><td>M—None</td></tr><tr><td>F—Private Medical Insurance</td><td>N—United Mine Workers</td></tr><tr><td></td><td>P—Black Lung</td></tr></tbody></table>	A—Part A, Medicare Only	G—Champus	B—Part B, Medicare Only	H—Health Maintenance Organization	C—Both Parts A & B Medicare	J—Other and / or Unknown	D—Blue Cross /Blue Shield	L—Absent Parent's Insurance	E—Blue Cross /Blue Shield Major Medical	M—None	F—Private Medical Insurance	N—United Mine Workers		P—Black Lung	
A—Part A, Medicare Only	G—Champus														
B—Part B, Medicare Only	H—Health Maintenance Organization														
C—Both Parts A & B Medicare	J—Other and / or Unknown														
D—Blue Cross /Blue Shield	L—Absent Parent's Insurance														
E—Blue Cross /Blue Shield Major Medical	M—None														
F—Private Medical Insurance	N—United Mine Workers														
	P—Black Lung														
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 206.634 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>															

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

APPENDIX II-D

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD CASE NUMBER FROM: 08-01-88 TO: 07-01-89 037 C 000123456		Smith, Jane Smith, Kim	1234567890 2345678912	2	0353	M
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601				2	1284	M
ISSUE DATE: 06-27-88		KENPAC PROVIDER AND ADDRESS Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 502-346-9832 PHONE				
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
SEE OTHER SIDE FOR SIGNATURE		MAP BENEFIT PLAN				

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

**APPENDIX II-D
(cont.)**

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES														
<p>This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Services."</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621</p>	<ol style="list-style-type: none"> The designated KenPAC primary provider must provide or authorize the following services: physician, hospital in-patient and out-patient, home health agency, laboratory, ambulatory surgical center, primary care center, renal health center, and nurse practitioner. Authorization by the primary provider is not required for services provided by registered nurses or licensed clinical social workers, for emergency services provided by an emergency department, or for other covered services not listed above. In the event of an emergency, payment can be made to a participating medical provider rendering services to the person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side. Covered services which may be obtained without prior authorization from the KenPAC primary provider include services from pharmacists, community mental health centers, nursing homes, intermediate care facilities, mental hospitals, nurse anesthetists, and participating providers of dental, hearing, vision, ambulation, non-emergency transportation, screening, family planning services, and testing services. Show this card to the person who provides these services to you whenever you receive medical care. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the first bottom and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card. If you have questions, contact your eligibility worker at the county office. Recipient not temporarily out of the state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. 														
<p>Insurance Identification</p> <table border="0"> <tr> <td>A—Part A, Medicare Only</td> <td>G—Chambers</td> </tr> <tr> <td>B—Part B, Medicare Only</td> <td>H—Health Maintenance Organization</td> </tr> <tr> <td>C—Both Parts A & B Medicare</td> <td>J—Other and / or Unknown</td> </tr> <tr> <td>D—Blue Cross / Blue Shield</td> <td>L—Absent Parent's Insurance</td> </tr> <tr> <td>E—Blue Cross / Blue Shield Major Medical</td> <td>M—None</td> </tr> <tr> <td>F—Private Medical Insurance</td> <td>N—United Mine Workers</td> </tr> <tr> <td></td> <td>P—Black Lung</td> </tr> </table>	A—Part A, Medicare Only	G—Chambers	B—Part B, Medicare Only	H—Health Maintenance Organization	C—Both Parts A & B Medicare	J—Other and / or Unknown	D—Blue Cross / Blue Shield	L—Absent Parent's Insurance	E—Blue Cross / Blue Shield Major Medical	M—None	F—Private Medical Insurance	N—United Mine Workers		P—Black Lung	<p>Signature _____</p>
A—Part A, Medicare Only	G—Chambers														
B—Part B, Medicare Only	H—Health Maintenance Organization														
C—Both Parts A & B Medicare	J—Other and / or Unknown														
D—Blue Cross / Blue Shield	L—Absent Parent's Insurance														
E—Blue Cross / Blue Shield Major Medical	M—None														
F—Private Medical Insurance	N—United Mine Workers														
	P—Black Lung														
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.634 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>															

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

**APPENDIX II-E
(cont.)**

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 606-684-6680.

You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

- | | |
|--|------------------------------------|
| A Part A Medicare Only | G Champus |
| B Part B Medicare Only | H Health Maintenance Organization- |
| C Both Parts A & B Medicare | J Other and or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance (false report changes relating to eligibility or permits use of the card by an ineligible person).

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Name and provider number of Lock-In physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES	
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS	
ELIGIBLE RECIPIENT & ADDRESS	FROM _____ TO _____
	ELIGIBILITY PERIOD
	PHYSICIAN NAME
	PHYSICIAN PROVIDER NO.
	MEDICAL ASSISTANCE IDENTIFICATION NUMBER
	SEX CODE
	INSURANCE
	DATE OF BIRTH MONTH YEAR
	CASE NUMBER
SEE OTHER SIDE FOR SIGNATURE	MAP 822A REV 11/88
	PHARMACY NAME
	PHARMACY PROVIDER NO.

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

Provider Number: _____
(If Known)COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

- (a) name;
- (b) ownership;
- (c) licensure/certification/regulation status; or
- (d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19____, with conditional termination on _____, 19____, and shall automatically terminate on _____, 19____, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

BY: _____
Signature of Authorized Official

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____
(Name) _____ (County)
2. _____
(Location Address, Street, Route No, P.O. Box)
3. _____
(City) _____ (State) _____ (Zip)
4. _____
(Office Phone# of Provider)
5. _____
(Pay to, In care of, Attention, etc. If different from above address.)
6. _____
Pay to address (If different from above)
7. Federal Employee ID No. _____
8. Social Security No. _____
9. License No. _____
10. Licensing Board (If applicable): _____
11. Original license date: _____
12. Kentucky Medicaid Provider No. (If known) _____
13. Medicare Provider No. (If applicable) _____
14. Practice Organization/Structure: _____ (1) Corporation
_____ (2) Partnership _____ (3) Individual
_____ (4) Sole Proprietorship _____ (5) Public Service Corporation
_____ (6) Estate/Trust _____ (7) Government/Non-Profit
15. Are you a hospital based physician (salaried or under contract
by a hospital)? _____ yes _____ no
Name of hospital(s) _____

16. If group practice, number of providers in group (specify provider type):

17. If corporation, name, address, and telephone number of corporate office:

Telephone No: _____

Name and address of officers:

18. If partnership, name and address of partners:

19. National Pharmacy No. (If applicable):
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:

___ Federal ___ State ___ County ___ City

___ Charitable or religious

___ Proprietary (Privately-owned) ___ Other

APPENDIX III

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:

Member: _____

Member: _____

30. Management Firm (If applicable):

31. Lessor (If applicable):

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____

34. Institutional Review Committee Members (If applicable):

35. Providers of Transportation Services:

Number of Ambulances in Operation: _____

Number of Wheelchair Vans in Operation: _____

Basic Rate \$ _____ (Includes up to _____ miles)

Per Mile \$ _____ Oxygen \$ _____

Extra Patient \$ _____ Other \$ _____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? ____ yes ____ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

Date: _____ Staff: _____

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day
of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for
Human Resources, Department for Medicaid Services, hereinafter referred to as the
Cabinet, and _____,

Name and Address of Provider

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in
the exercise of its lawful duties in relation to the administration of the Kentucky
Medical Assistance Program (Title XIX) is required by applicable federal and state
regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance
Program (KMAP) as a

Type of Provider and/or Level of Care) _____ (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the
parties hereto as follows:

1. The Provider:

- A. Desires to submit claims for services provided to recipients of the
Kentucky Medical Assistance Program (Title XIX) via electronic media
rather than via paper forms prescribed by the KMAP.
- B. Agrees to assume responsibility for all electronic media claims,
whether submitted directly or by an agent.
- C. Acknowledges that the Provider's signature on this Agreement Addendum
constitutes compliance with the following certification required of
each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accu-
rate, and complete and that any subsequent transactions which alter
the information contained therein will be reported to the KMAP. I
understand that payment and satisfaction of these claims will be
from Federal and State funds and that any false claims, statements,
or documents or concealment of a material fact, may be prosecuted
under applicable Federal and State Law."

- D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.
 - E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.
 - F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.
 - G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.
2. The Cabinet:
- A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.
 - B. Agrees to assign to the provider or its agent a code to enable the media to be processed.
 - C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Provider

BY: _____
Signature of Authorized Official
or Designee

Contact Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)
_____, to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;
2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

Signature, Authorized Agent of Billing Agency

Date: _____

Contact Name: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

Signature, Representative of the
Department for Medicaid Services

Date: _____

ADULT DAY HEALTH CARE PROCEDURE CODES

The Kentucky Medical Assistance Program locally assigned Health Care Financing Administration Common Procedure Coding System (HCPCS) codes for Adult Day Health Care Services are as follows:

The first digit is an X (left to right) and is a constant for the Home and Community Based Services Waiver Program.

The second digit is an R and refers to Adult Day Health Care Service.

The third digit identifies the specific adult day health care service provided:

- 0 Basic Daily Service
- 4 Physical Therapy Service
- 5 Occupational Therapy Service
- 6 Speech Therapy Service

The last two digits identify the primary procedure provided. Basic daily services and ancillary services MUST be entered on separate lines.

XR000 Basic Daily Service

Units of Service: $\frac{1}{2}$ day equals 1 unit
1 full day equals 2 units

ADULT DAY HEALTH CARE SERVICES MANUAL

ADULT DAY HEALTH CARE PROCEDURE CODES

XR400-XR499 PHYSICAL THERAPY SERVICES

- XR400 Initial Evaluation of patient for Physical Therapy Program
- XR401 Patient Assessment for Physical Therapy Program through applying muscle, nerve, joint and functional ability tests
- XR402 Training and instructions for patient/family in setting up and following a Physical Therapy Program
- XR403 Follow-up visit to evaluate progress of therapy program established in #402
- XR404 Gait evaluation and training
- XR405 Therapeutic exercise program by therapist (including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, increased range of motion)
- XR406 Transfer Training
- XR407 Instructions in the care and use of wheelchairs, braces, crutches, canes, prosthesis and/or orthotic devices
- XR408 Breathing Exercises, Percussion/Postural Drainage/Vibration for Pulmonary Functioning
- XR409 Teaching compensatory technique to improve the level of independence in activities of daily living
- XR410 Other Physical Therapy visit (Identify in Item #15, Procedure/Supply Description column)
- XR411-XR499

Units of Service - A unit of service would be a patient encounter.

ADULT DAY HEALTH CARE PROCEDURE CODES

XR500-XR599 OCCUPATIONAL THERAPY

- XR500 Initial Evaluation of patient's level of function for Occupational Therapy Program
- XR501 Visit for training for better coordination, use of senses and perception
- XR502 Therapeutic exercise program by therapist (including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, increased range of motion)
- XR503 Instructions for patient and/or family in setting up and following an occupational therapy program
- XR504 Follow-up visit to evaluate progress of patient and/or family in following program set up in #503
- XR505 Teaching compensatory technique to improve the level of independence activities of daily living
- XR506 Designing and fitting of orthotic and self-help devices (i.e. hand splint for patient with rheumatoid arthritis)
- XR507 Other Occupational Therapy visit (Identify in Item #15, Procedure/Supply Description column)
- XR508-XR599

Units of Service - A unit of service would be a patient encounter.

XR600-XR699 SPEECH THERAPY SERVICES

- XR600 Initial Evaluation of patient for Speech Therapy Program (Determines and recommends the appropriate speech and hearing service)
- XR601 Instructions for patient and/or family in setting up and following a Speech Therapy Program
- XR602 Followup visit to evaluate the progress of Speech Therapy Program set up in #601
- XR603 Visit to provide rehabilitative services for speech, hearing, and language disorders
- XR604 Miscellaneous Speech Therapy visit (Please identify in Item #15, Procedure/Supply Description column)
- XR605-XR699

Units of Service - A unit of service would be a patient encounter.

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APPENDIX VI

APPROVED OMB-2933-0038

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
FICA									
MEDICARE		MEDICAID		CHAMPUS		CHAMPVA		GROUP HEALTH PLAN	
FECA		BLK LUNG		OTHER					
Medicare #		Medicaid #		Sponsor's SSN		VA File #		SSN or ID	
1. INSURED'S I.D. NUMBER				FOR PROGRAM IN ITEM 11					
2. INSURED'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
4. INSURED'S ADDRESS (No., Street)				5. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
6. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)					
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				9. INSURED'S ADDRESS (No., Street)					
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER					
12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				13. INSURED'S POLICY GROUP OR FECA NUMBER					
14. EMPLOYER'S NAME OR SCHOOL NAME				15. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
16. EMPLOYER'S NAME OR SCHOOL NAME				17. INSURED'S POLICY GROUP OR FECA NUMBER					
18. INSURANCE PLAN NAME OR PROGRAM NAME				19. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d					
20. READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM.				21. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE				23. SIGNED					
24. DATE				25. DATE					
26. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				27. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
28. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
30. RESERVED FOR LOCAL USE				31. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)				33. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
34. PRIOR AUTHORIZATION NUMBER				35. MEDICAID RESUBMISSION CODE					
36. MEDICAID RESUBMISSION CODE				37. PRIOR AUTHORIZATION NUMBER					
38. MEDICAID RESUBMISSION CODE				39. PRIOR AUTHORIZATION NUMBER					
39. MEDICAID RESUBMISSION CODE				40. PRIOR AUTHORIZATION NUMBER					
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98. MEDICAID RESUBMISSION CODE				99. PRIOR AUTHORIZATION NUMBER					
99. MEDICAID RESUBMISSION CODE				100. PRIOR AUTHORIZATION NUMBER					

AS OF 01/06/92

APPENDIX VII
Page 1

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER
RA SEQ NUMBER 2
PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
23104	DONALDSON R	3834042135	9883324-552-580	123191-123191	50.00	2.00	0.00	48.00	365
1 PS 3	PROC-01234	QTY 5		123191-123191	30.00	0.00		30.00	61
2 PS 3	PROC 12345	QTY 5		123191-123191	20.00	2.00		18.00	365

CLAIMS PAID IN THIS CATEGORY: 1

TOTAL BILLED: 50.00

TOTAL PAID: 48.00

APPENDIX VII
Page 1

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/'92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4321712345	9838348-552-010	123191-123191	30.00	254
01 PS 6	PROCEDURE 11122	QTY 1		123191-123191	30.00	

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/92

RA NUMBER 2 PROVIDER NAME
RA SEQ NUMBER PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* CLAIMS IN PROCESS *

VOICE NUMBER	-RECIPIENT IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
1384	JOHNSON P 2471340401	9883342-564-210	123191-123191	32.00	260
4632	MITCHELL J 4331740410	9883347-575-240	123191-123191	24.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 56.00

AS OF 01/06/92 KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER 2 PROVIDER NAME
RA SEQ NUMBER PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	EOB
324789	SMITH	4838021143	9883324-552-060	123191-123191
				999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	48.00	0.00	48.00	0.00	48.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/92

RA NUMBER
RA SEQ NUMBER 2 PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

PAID IN FULL BY MEDICAID
THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
ELIGIBILITY DETERMINATION IS BEING MADE
FEE ADJUSTED TO MAXIMUM ALLOWABLE
REQUIRED INFORMATION NOT PRESENT

061
254
260
365
999

THIRD PARTY LIABILITY
LEAD FORM

ipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address : _____

Policy #: _____ Start Date: _____ End Date: _____

Date Filed with Carrier : _____

Provider Name : _____ Provider #: _____

Comments: _____

Signature: _____ Date: _____

PROVIDER INQUIRY FORM

EDS

P.O. Box 2009
Frankfort, Ky. 40602

Please remit **both**
copies of the Inquiry
Form to EDS.

1. Provider Number	3. Recipient Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
	7. RA Date	8. Internal Control Number
9. Provider's Message		

10. _____
Signature Date

Dear Provider:

☐ This claim has been resubmitted for possible payment.
☐ EDS can find no record of receipt of this claim. Please resubmit.
☐ This claim paid on _____ in the amount of _____.
☐ We do not understand the nature of your inquiry. Please clarify.
☐ EDS can find no record of receipt of this claim in the last 12 months.
☐ This claim was paid according to Medicaid guidelines.
☐ This claim was denied on _____ with EOB code _____

☐ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

EDS

Date

MAIL TO: **EDS FEDERAL CORPORATION**
P. O. BOX 2009
FRANKFORT, KY 40602

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.)												EDS FEDERAL USE ONLY											
2. Recipient Name												3. Recipient Medicaid Number											
4. Provider Name/Number/Address												5. From Date Service						6. To Date Service					
												7. Billed Amt.						8. Paid Amt.					

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature

13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

Field/Line:

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

er Actions/Remarks:

APPENDIX XI

1. Check Number		2. Check Amount	
3. Provider Name/Number/Address		4. Recipient Name	
		5. Recipient Number	
6. From Date of Service	7. To Date of Service	8. RA Date	
9. Internal Control Number (If several ICNs attach RAs)			

___ a. Payment from other source - Check the category and list name
 ___ Health Insurance (attach a copy of EOB)
 ___ Auto Insurance
 ___ Medicare paid
 ___ Other _____

___ b. Billed in error

___ c. Duplicate payment (attach a copy of both RA's)
 If RA's are paid to 2 different providers specify to which provider
 number the check is to be applied.

___ d. Processing error OR Overpayment
 Explain why _____

___ e. Paid to wrong provider

___ f. Money has been requested - date of the letter ___/___/___
 (Attach a copy of letter requesting money)

___ g. Other

Contact Name _____ Phone: _____



CABINET FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY
FRANKFORT 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/H"

Adult Day Health Care Services
Manual Transmittal Letter # 18

Dear Provider:

This letter transmits a complete revision to the Kentucky Medicaid Adult Day Health Care Service Provider Manual. Please replace all previous Adult Day Health Care Services Manuals with this latest edition. Manual changes include the following:

- 1) The manual has changed to show that the billing form is the Health Insurance Claim Form, HCFA-1500, (Rev. 12-90). Instructions for completing this form are included in the manual. Refer to pages 7.1-7.8.
- 2) Additional information has been included regarding the Home-and Community-Based Waiver Program's assessments and reassessments for clarification. Refer to pages 3.3-3.4.
- 3) Additional information is included in the Condition for Participation Section regarding ownership, disclosure of information, withdrawal of participation, patient consent forms, and medical records.
- 4) The procedures for cash refunds have been included. Refer to pages 9.6-9.7. The Cash Refund Documentation form has been included as Appendix XI.

If you have questions please contact the Division of Program Services, Alternative Services Branch at (502) 564-6890. Your continued cooperation with the Medicaid Program is appreciated.

Sincerely,

Roy Butler, Commissioner
Department for Medicaid Services

RB/dw

Enclosure

Remove and Destroy

Entire Manual Transmittal # 7

Insert

Entire Manual Transmittal # 8

ADULT DAY HEALTH CARE SERVICE MANUAL

**Kentucky Medicaid ~~[Medical Assistance]~~ Program
Adult Day Health Care Benefits
Policies and Procedures**



**Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621**

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SECTION I - INTRODUCTION

A. INTRODUCTION

This new edition of the Kentucky Medicaid ~~[Medical Assistance]~~ Program Adult Day Health Care Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid ~~[Medical Assistance]~~ Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will ~~[-, hopefully,]~~ assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, 275 East Main Street [CHR Building], Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, 275 East Main Street [CHR Building], Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 756-7557 ~~[333-2188]~~ or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

~~[C. Electronic Media Claims (EMC)]~~

~~Electronic Media Claims (EMC) is a means by which Adult Day Care providers can submit claims electronically. EMC enables providers to experience an improved cash flow, fewer errors in claims processing, and a reduction in effort with claim preparation. Claims can be submitted electronically in a variety of different ways such as via magnetic tape, diskette, or modem.~~

~~Claims that require attachments cannot be submitted electronically.~~

~~For more information regarding EMC, contact an EMC Representative at (502) 227-9073 or 1-(800)-756-7557 [333-2188]. You may also write to EDS, P.O. Box [2008] 2009, Frankfort, Kentucky 40602.]~~

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

II. KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] PROGRAM [~~(KMAP)~~]

A. General Information

The Kentucky Medicaid [~~Medical Assistance~~] Program[~~; frequently referred to as the Medicaid Program;~~] is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid [~~Medical Assistance~~] Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department shall [~~can~~] not reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid [~~Medical Assistance~~] Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age. The Kentucky Medicaid Program serves eligible recipients of all ages.

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid [~~Medical Assistance~~] benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid [~~Medical Assistance~~] Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven member are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid [~~Medical Assistance~~] Program [~~hereinafter referred to as KMAP;~~] is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Program have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid [~~Medical Assistance~~] Program has secondary liability. Accordingly, the provider of service shall [~~should~~] seek reimbursement from such third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid [~~the KMAP~~] before knowing of the third party's liability, a refund of that payment amount should be made to Medicaid [~~the KMAP~~], as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid [~~Medical Assistance~~] Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his [~~or her~~] medical care.

When the Department make payment for a covered services and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and [~~for~~] imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

All services are reviewed for recipients and provider abuse. Willful abuse by the provider may result in his [~~or-her~~] suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he [~~or-she~~] receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medicaid [~~Medical Assistance~~] Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and that [~~such~~] payment is accepted by the provider as either partial payment of payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--

- (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,
- (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
- (3) having knowledge of the occurrence of any event affecting
 - (A) his initial or continued right to any such benefit or payment, or
 - (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~((KMAP))~~]

- (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

- (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
 - (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
- (3) Paragraphs (1) and (2) shall not apply to--
- (A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and
 - (B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.
- (c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

SECTION II - KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] [~~(KMAP)~~]

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,
when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

[~~F. Timely Submission of Claims~~]

~~In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by EDS within twelve (12) months from the date of service. Claims received after the date will not be payable. This policy became effective August 23, 1979.]~~

[~~G. Medical Records~~]

~~Medical records must be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.]~~

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Definition of Adult Day Health Care

Adult Day Health Care is a program of services provided under health leadership in an ambulatory care setting for adults who due to physical ~~[and/]~~ or mental impairment, are not capable of full time independent living. Participants in the Adult Day Health Care Program must meet all eligibility requirements under the Home and Community Based Services Waiver and be referred to the Adult Day Health Care Program by the Home and Community Based Services Provider and their attending physician. The essential elements of a day health care program are directed toward meeting the health maintenance and restoration needs of the recipient. However, there are socialization elements in the program which relate to the isolation so often associated with illness in the aged and disabled, and which are considered vital for the purpose of fostering and maintaining the maximum possible state of health and well being.

Licensed Adult Day Health Care Centers, including long term care facilities which are appropriately licensed in Kentucky for the provision of adult day health care services, may be certified for participation in the Medicaid [KMAP]. The Center must have obtained a certificate of need ~~[, a license from the Certificate of Need and Licensure Board, and have met the requirements for certification as a provider of]~~ from the Commission for Health Economics Control and have met the requirements for licensure as Adult Day Health Care services. Participating centers shall required to meet all applicable federal, state, and local requirements.

B. Application for Participation

In order to participate in the Home and Community Based Services Program ~~[Waiver Project]~~ as a provider of adult day health care, the center ~~[agency]~~ must complete an application to participate which includes:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344)

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Additionally, the Adult Day Health Care Center must submit a verification of current license. Both copies of the MAP-343, the MAP-344, a Statement related to services and charges, and the license verification, are to be submitted to:

Division of Program Services
ATTN: Provider Enrollment
Department for Medicaid Services
Cabinet for Human Resources
275 East Main Street
Frankfort, KY 40621

The yellow copy of the Application for Participation (MAP-343), ~~[signed by the Director,]~~ will be returned to the center ~~[agency]~~ along with a cover letter indicating the provider number and effective date of participation. Questions regarding enrollment may be addressed to Provider Enrollment, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621 or Phone (502) 564-3476.

Services must be furnished by the participating Adult Day Health Care Center or by others under approved contractual arrangements with the Center. Only those arrangements or contracts made by the Adult Day Health Care Center with another health organization or individual approved by the Division of Licensing and Regulations will be acceptable by Medicaid ~~[KMAP]~~. Arrangements made by an Adult Day Health Care Center with others to provide services must be stipulated in such a way that receipt of payment by the Adult Day Health Care Center for the service (whether in its own right or as an agent) discharges the liability of the recipient or Medicaid ~~[the KMAP]~~ to make any additional payment for such services.

C. The Home-and Community-Based Program and Provision of Adult Day Health Care Services as a Part of that Program

Adult Day Health Care Services are only covered as a part of the Home-and Community-Based (HCB) Program. HCB Program services provided by Medicaid certified HCB Program providers shall be payable by the Medicaid Program, when provided to Medicaid recipients who have

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been determined by the Professional Review Organization (PRO) to meet the level of care for Nursing Facility services, and have been prior authorized by the Department for Medicaid Services to receive HCB Program Services. The physician shall order the services and certify that if waiver services were not available, he would order Nursing Facility services, and the individual would be admitted in the immediate future.

It shall be the responsibility of the Home-and Community-Based (HCB) provider to initiate the assessment and certification process to determine whether the recipient is eligible to receive HCB services including Adult Day Health Care. The HCB provider shall:

1. Obtain the physician's orders for services and certification regarding need for nursing facility level of care,
2. Obtain the level of care determination by the professional review organization, and
3. Obtain prior authorization to provide the HCB services from the Department for Medicaid Services.

The HCB provider shall be responsible for providing all HCB recipients at least one case management contact per month (every 30-31 days) to assess the service delivery. This contact may be by telephone or face-to-face. However, a face-to-face contact with the recipient shall be made at least every other month. The face-to-face contact with the adult day health care recipient may be made while the recipient is at the adult day health care center.

The HCB provider shall provide reassessment and recertification regarding the continuing need for HCB services at least every six (6) months. The same general procedures used for the initial assessment apply to the reassessment. Medicaid reimbursement shall not be available for any waiver service (including Adult Day Health Care) provided during any period of time that the recipient is not covered by a valid Level of Care Certification or has not been reassessed and prior authorized. Additionally, if more than sixty (60) days have elapsed since the end of the previous certification period, the recipient will be considered terminated from the HCB Program.

It shall also be the responsibility of the Adult Day Health Care provider to assure that all HCB recipients receiving Adult Day

SECTION III - CONDITIONS OF PARTICIPATION

Health Care Services have been appropriately reassessed and recertified.

~~123~~ ~~[Provision of Adult Day Health Care Services]~~

~~[The home and community based service provider will perform the initial patient/recipient assessment to determine the individual's overall care needs and eligibility for home and community based services, including adult day health care. Although the home and community based service provider must arrange for the provision of Adult Day Health Services, reimbursement will be made directly to the adult day health care center providing the services.]~~

Although the HCB provider shall arrange for the provision of the Adult Day Health Care Services the HCB provider shall [will] develop its own plan of treatment for the services provided to the recipient in accordance with the care need findings of the comprehensive assessment and the physician's orders. (Information obtained through the initial assessment shall be used in conjunction with any additional information.)

Reimbursement shall be made directly to the adult day health care provider for Adult Day Health Care Services provided by the Center.

Adult Day Health Care Services are to be furnished to Medicaid ~~[KMAP]~~ recipients eligible under the Waiver by members of the health team in the adult day health care center. The health team should include but not be limited to the following: Physician, Registered Nurse, Activities Director, Physical Therapist, Speech Pathologist, Social Worker, Nutritionist, Health Aide, and Occupational Therapist (if available).

1. Plan of Treatment

Adult Day Health Care Services are provided to Medicaid ~~[KMAP]~~ recipients eligible under the waiver in accordance with a physician's plan of treatment for Adult Day Health Care Services.

The plan of treatment developed by the physician in consultation with appropriate agency staff shall cover all pertinent diagnoses, mental status, types of services required, frequency of visits to the center, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional re-

quirements, medications, and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Any additions or modifications to the original plan of treatment are to be indicated on a change of order form, signed by the physician and[or] included in the recertification. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency and duration of such therapy service. Individual plans would need to be developed for therapy services.

SECTION III - CONDITIONS OF PARTICIPATION

- a. CONFORMANCE WITH PHYSICIAN'S ORDERS: Drugs and treatments are administered by Center staff only as ordered by the physician. The nurse or therapist shall immediately record and sign oral orders and obtain the physician's countersignature as soon as possible. Center staff shall evaluate and monitor all patient medications for possible adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.
- b. REVIEW OF PLAN OF TREATMENT: The total plan of treatment shall be reviewed by the recipient's physician and Center personnel as often as every 90 days. Included in the review of the plan of care shall be the physician's certification~~[-]~~ or recertification of the need for continued care.

Responsibility for assuring that the Adult Day Health Care Services continue to maintain the recipient ~~[patient]~~ at the maximum level possible will be assumed by the physician and the Health Team. Evaluations should be made at the time of recertification, or earlier, if the severity of the recipient's ~~[patient's]~~ illness indicates the need for institutionalization or another type of care.

Should a recipient's ~~[patient's]~~ condition become such that a different type of care would be more beneficial, the Center staff shall make the necessary transfer or referral and advise the Home and Community Based Services Provider of such referral or transfer. The Home and Community Based Services Provider shall ~~[would]~~ notify the Department for Medicaid Services.

SECTION III - CONDITIONS OF PARTICIPATION

D. Termination of Provider Participation

907[4] KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid ~~[Medical Assistance]~~ Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;
3. Misrepresenting factors concerning a facility's qualifications as a provider;
4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or
5. Submitting false or questionable charges to the agency.

SECTION III - CONDITIONS OF PARTICIPATION

The Kentucky Medicaid [Medical Assistance] Program shall notify a provider in writing at least thirty (30) [~~fifteen (15)~~] days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;
2. The effective date;
3. The extent of its applicability to participation in the Medicaid [~~Medical Assistance~~] Program;
4. The earliest date on which the Cabinet will accept a request for reinstatement;
5. The requirements and procedures for reinstatement; and
6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;
2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;
3. Counsel representing the provider;

SECTION III - CONDITIONS OF PARTICIPATION

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and
5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or nonrenewal of the provider agreement or of suspension from the Kentucky Medicaid ~~[Medical Assistance]~~ Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid ~~[Medical Assistance]~~ Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

E. Change of Ownership

The Adult Day Health Care Provider shall ~~[must]~~ complete new participation agreement forms whenever the agency has a change of ownership. The information and forms necessary to complete the application to participate in the Medicaid ~~[KMAP]~~ are:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344); and
3. Verification of current Adult Day Health Care license.

These forms shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency, the name of the new agency and the effective date of the change.

SECTION III - CONDITIONS OF PARTICIPATION

F. Disclosure of Information (42 CFR 405, 420, 413 and 455)

There are some requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act.) The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). The portions applicable to Medicaid are outlined for you. The regulations are significant and we suggest your attention to them.

Of particular impact on Medicaid providers are the following:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX, or XX.
2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.
3. The Secretary may have access to Medicaid provider records.
4. Providers are required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

G. Withdrawal of Participation

If a provider withdraws participation in Medicaid, written notice shall be given to the Cabinet for Human Resources, Department for Medicaid Services at least thirty (30) days prior to the effective date of withdrawal. Payment may not be made for services or items provided to recipients on or after the effective date of withdrawal.

SECTION III - CONDITIONS OF PARTICIPATION

H. Patient Consent Forms

Please be advised that neither the Office of Inspector General (Licensing and Regulation or Audits) nor Medicaid personnel are required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid Program.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare shall be appealed through Medicare procedures.

I. Medical Records

Medical records shall substantiate the services billed to Medicaid by the Home Health Agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

Medical records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

SECTION IV - COVERED SERVICES

IV. COVERED SERVICES

A. Basic Services

Adult Day Health Care Service coverage shall include reimbursement for basic and certain ancillary services.

Basic services shall include:

1. One meal per day including special diets;
2. Snacks, as appropriate;
3. R.N. and other supervision;
4. Regularly scheduled daily activities
5. Routine services required to meet daily personal and health care needs;
6. Equipment essential to the provision of adult day health care services; and
7. Incidental supplies necessary to provide adult day health care services.

B. Ancillary Services

The following ancillary services are included as covered services through the Adult Day Health Care element of Medicaid ~~[the KMAP]~~, when provided to a recipient eligible under the Waiver in an Adult Day Health Care Center and ordered by a physician in a plan of treatment:

As appropriate, physical, occupational, or speech therapy may be provided as ancillary services by the adult day health care center under contractual arrangement with a qualified therapist in accordance with the plan of treatment. It is expected that generally these services shall consist of evaluations (reevaluations), for the purpose of developing a plan which could be carried out by the recipient ~~[patient and]~~ or Adult Day Health Care Center staff. However, individualized therapy services provided by the therapist to a recipient in accordance with the plan of treatment may be covered as ancillary services. The qualified therapist assists the physician in evaluating the level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with other center personnel and participates in inservice programs.

SECTION IV - COVERED SERVICES

1. Physical therapy shall include such services as:
 - a. Assisting the physician to evaluate the recipient for physical therapy through the application of muscle, nerve, joint and functional ability tests.
 - b. Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion.
 - c. Gait evaluation and training.
 - d. Transfer training and instructions in care and use of wheelchairs, braces, and prosthesis, etc.
 - e. Instruction in breathing exercises, percussion, postural drainage, vibration for pulmonary functioning.
 - f. Teaching compensatory technique to improve the level of independence in activities of daily living.
 - g. Training and instructions for recipient or ~~[pa-~~
~~-tient/]~~center staff in setting up and following a physical therapy program.

Standard:

The physical therapist shall ~~[must]~~ be qualified and appropriately licensed by the State of Kentucky as a physical therapist.

SECTION IV - COVERED SERVICES

Specific Guidelines:

The services shall ~~[must]~~ be reasonable and necessary for the recipient's ~~[patient's]~~ condition and of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of procedures which could be safely and effectively provided by the recipient ~~[patient/]~~ or Center staff.

2. Occupational therapy shall include such services as:
 - a. Assisting the physician to evaluate the recipient for occupational therapy services through the appropriate testing technique.
 - b. Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion.
 - c. Assisting the recipient ~~[patient]~~ to obtain better coordination, use of senses and perception.
 - d. Instructing the recipient ~~[patient and/]~~ or adult day health care center staff in setting up and following an occupational therapy program.
 - e. Teaching compensatory technique to improve the level of independence in activities of daily living.
 - f. Designing and fitting orthotic and self-help devices (i.e., hand splints for the patient with rheumatoid arthritis).

Standard:

The occupational therapist shall ~~[must]~~ be qualified as an occupational therapist and registered by the American Occupational Therapy Association.

SECTION IV - COVERED SERVICES

Specific Guidelines:

The services shall ~~[must]~~ be reasonable and necessary for the recipient's ~~[patient's]~~ condition and must be of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of procedures which could be safely and effectively provided by the recipient or ~~[patient/]~~ center staff.

3. Speech pathology shall include such services as:

- a. Assisting the physician to evaluate the recipient for speech pathology service through the appropriate testing techniques.
- b. Determining and recommending appropriate speech and hearing services.
- c. Providing necessary rehabilitative services for recipient ~~[patient]~~ with speech, hearing, or language disabilities.
- d. Instructions for the recipient ~~[patient and/]~~ or adult day health care center staff in setting up and following a speech pathology program.

Standard:

The speech pathologist shall ~~[must]~~ be qualified and appropriately licensed by the State of Kentucky as a speech pathologist.

Specific Guidelines:

The services shall ~~[must]~~ be reasonable and necessary for the recipient's ~~[patient's]~~ condition and of such complexity that they must be performed by the qualified therapist. A maintenance program should be developed for the performance of simple procedures which could be safely and effectively provided by the recipient ~~[patient/]~~ or center staff.

SECTION IV - COVERED SERVICES

C. Non-Covered Services

Examples of services not covered under the Adult Day Health Care element are as follows:

1. The Medicaid ~~[KMAP]~~ recipient did not meet level of care for the waiver.
2. Transportation is not covered under this service element, but is a separately reimbursable service pursuant to 907~~[4]~~ KAR 1:060, Medical Transportation.

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

Reimbursement for Adult Day Health Care Services shall be paid directly to the licensed participating Adult Day Health Care Center on the basis of an interim rate with a year-end cost settlement to the lower of actual reasonable allowable costs or charges. The basic rate shall not exceed eighty (80) percent of the maximum Medicaid [KMAP] intermediate care reimbursement rate for routine services. Reimbursement for ancillary services shall not exceed eighty (80) percent of the approved maximum reimbursement rate for therapy services under the Medicaid [KMAP] home health program element.

A separate reimbursement manual has been developed to outline the Principles of Reimbursement for Adult Day Health Care Services. Please refer to the Adult Day Health Care Reimbursement Manual.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

VI. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall ~~[must]~~ actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, it shall be ~~[he/she should]~~ determined if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid ~~[Medical Assistance]~~ Program all participating vendors shall submit billings for medical services to a third party when such vendor has prior knowledge that such third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- If the recipient is a minor, ask about insurance the MOTHER, FATHER or GUARDIAN may carry on the recipient;
- In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- For people over 65 or disabled, seek a MEDICARE HIC number;
- Ask if the recipient has health insurance such as a MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding insurance.

Following is a list of the insurance codes on the MAID card:

- A - Part A, Medicare only
- B - Part B, Medicare only
- C - Both parts A and B Medicare
- D - Blue Cross, ~~[A]~~Blue Shield
- E - Blue Cross, ~~[A]~~Blue Shield, ~~[A]~~Major Medical
- F - Private medical insurance
- G - Champus
- H - Health Maintenance Organization
- J - Other [and/]or unknown
- L - Absent Parent's insurance
- M - None
- N - United Mine Workers
- P - Black Lung

C. Billing Instructions for Claims Involving Third Party Resources

If the patient has third party resources that will pay for Adult Day Health Care Services, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

Exceptions:

*If the other insurance company has not responded within 120 days of the date of filing a claim to the insurance company, the provider shall submit a claim to EDS in the usual manner with a completed Third Party Liability (TPL) Lead Form attached which states, no response over 120 days. The EDS Third Party Liability Unit will verify coverage with the insurance company, update the recipient's file, if necessary, and bill the third party, if appropriate. ~~[submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed form to:]~~

~~[EDS—
P.O. Box 2009—
Frankfort, KY 40602
Attn: TPL Unit]~~

*If proof of denial for the same recipient for the same or related services from the insurance company is attached to the Medicaid billing, claims processing can proceed. The denial shall not ~~[can not]~~ be more than six months old.

*A letter from the provider indicating that he[/she] contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, may ~~[can]~~ also be attached to the Medicaid claim.

D. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for the Kentucky Medicaid Program [KMAP] payment ~~[will]~~ shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall ~~[will]~~ be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid ~~[KMAP]~~ payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers shall ~~[must]~~ accept Medicaid payment as payment in full.



CABINET FOR HUMAN RESOURCES
COMMONWEALTH OF KENTUCKY
FRANKFORD 40621-0001

Anita
Jante

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/H"

APR 10 1992

COMMISSIONER'S OFFICE

TO: Roy Butler, Commissioner
Department for Medicaid Services

FROM: Jean Y. Farrisee, Director *JYF*
Division of Program Services

DATE: April 9, 1992

SUBJECT: Adult Day Health Care Services
Manual Transmittal #8

Attached for your review is the Adult Day Health Care Services Manual Transmittal #8. Please review and return comments by close of business Monday, April 13, 1992.

Thank you for your cooperation.

JYF/rwt

Attachment

cc: Mark Birdwhistell
Larry McCarthy
Adele Dickerson
Patricia Lynch
Cheri Reagan
Betty Weaver
Barbara Knox



CABINET FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY

FRANKFORT 40621-0001

DEPARTMENT FOR MEDICAID SERVICES

"An Equal Opportunity Employer M/F/H"

Adult Day Health Care Services Manual Transmittal Letter # 18

Dear Provider:

This letter transmits a complete revision to the Kentucky Medicaid Adult Day Health Care Service Provider Manual. Please replace all previous Adult Day Health Care Services Manuals with this latest edition. Manual changes include the following:

- 1) The manual has changed to show that the billing form is the Health Insurance Claim Form, HCFA-1500, (Rev. 12-90). Instructions for completing this form are included in the manual. Refer to pages 7.1-7.8.
- 2) Additional information has been included regarding the Home-and Community-Based Waiver Program's assessments and reassessments for clarification. Refer to pages 3.3-3.4.
- 3) Additional information is included in the Condition for Participation Section regarding ownership, disclosure of information, withdrawal of participation, patient consent forms, and medical records.
- 4) The procedures for cash refunds have been included. Refer to pages 9.6-9.7. The Cash Refund Documentation form has been included as Appendix XI.

If you have questions please contact the Division of Program Services, Alternative Services Branch at (502) 564-6890. Your continued cooperation with the Medicaid Program is appreciated.

Sincerely,

Roy Butler, Commissioner
Department for Medicaid Services

RB/dw

Enclosure

Remove and Destroy

Entire Manual Transmittal # 7

Insert

Entire Manual Transmittal # 8

SECTION VI - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE
(EXCLUDING MEDICARE)

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider shall ~~[must]~~ pursue payment with this third party resource before billing Medicaid again.

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 756-7557 ~~[333-2188]~~.

E. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall ~~[should]~~ pursue information relating to the accident. If an attorney, employer, individual or an insurance company is liable for payment, payment must be pursued from the liable party. If the liable party has not been determined, attach copies of any information obtained; ~~[, such as,]~~ the name of attorneys, other involved parties and ~~[for]~~ the recipient's employer to the claim when submitting to EDS for Medicaid payment.

SECTION VII - COMPLETION OF THE INVOICE FORM

VII. COMPLETION OF THE INVOICE FORM

A. General Information

The Health Insurance Claim Form, HCFA-1500 (12-90), shall ~~[Medical Assistance Statement, General Medical (MAP-4) should]~~ be used to bill for services rendered by Adult Day Health Care Centers to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

The original of the two part invoice set should be submitted to EDS as soon as possible after service is provided. The yellow copy of the invoice should be retained by the provider's office as a record of claim submittal.

Invoices should be mailed to:

E.D.S.
P.O. Box 2018 ~~[2053]~~
Frankfort, Kentucky 40602

1. General Billing Instructions

- a. The Health Insurance Claim Form, HCFA-1500 (12-90), shall ~~[Medical Assistance Statement, General Medical (MAP-4) must]~~ be used in billing for all covered Adult Day Health Care Services rendered to Medicaid ~~[KMAP]~~ recipients eligible under the Waiver.
- b. The Health Insurance Claim Form, HCFA-1500 (12-90), shall ~~[General Medical MAP-4 invoice should]~~ be submitted at least monthly. It is emphasized that prompt and regular billing will be beneficial to the center as there would be less chance of the center receiving retroactive denials covering several months.

SECTION VII - COMPLETION OF THE INVOICE FORM

- c. Claims for covered services must be received by EDS within twelve (12) months from the date of service. Claims for covered services shall be received by EDS within 12 months from the date of service. Claims with service dates greater than twelve (12) months can only be processed with appropriate documentation such as one or more of the following: Remittance Statements no more than 12 months of age which verify timely filing; backdated MAID cards with "Backdated Card" written on the attached claim; Social Security documents; correspondence describing extenuating circumstances; Action Sheets, Return to Provider Letters; Medicare Explanation of Medical Benefits, etc. [Claims received after that date will not be payable.]

~~[d. It is possible that a single billing statement could include services rendered in different calendar months. It is emphasized, however, that prompt and regular billing will be beneficial for the Center.]~~

- d. ~~[e.]~~ A separate billing statement shall ~~[must]~~ be used for each recipient.

- e. ~~[f.]~~ A separate line must be completed for each day of service.

- f. ~~[g.]~~ A separate line must be completed when billing for covered ancillary services. The services should be entered singularly according to type of service. Please refer to the HCPCS procedure code list for ancillary services (Appendix V ~~[IV]~~).

~~[h. The category of services for Adult Day Health Care is #53.]~~

- ~~i. In the event Adult Day Health Care Services are billed to EDS and denied payment, the Center staff may submit additional information which would affect the decision to the Department for Medicaid Services.]~~

SECTION VII - COMPLETION OF THE INVOICE FORM

B. Procedural Coding

On May 1, 1985, Kentucky Medicaid [~~KMAP~~] adopted, for procedural coding purposes, the HCFA Common Procedure Coding System (HCPCS). Refer to Appendix V for procedure codes.

C. Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), [~~Medical Assistance Statement, General Medical (MAP-4)~~]

An example of the Health Insurance Claim Form, HCFA-1500 (12-90), [~~Medical Assistance Statement, General Medical (MAP-4)~~] may be found in Appendix IV. Instructions for the proper completion of this form are presented below.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. The Medicaid Program [~~KMAP~~] cannot make payment for services rendered to an ineligible person.

BLOCK NO.

ITEM NAME AND DESCRIPTION

~~1-----RECIPIENT LAST NAME~~

~~Enter the last name of the recipient EXACTLY as it appears on his/her current Medical Assistance Identification (MAID) card.~~

~~2-----FIRST NAME~~

~~Enter the first name of the recipient EXACTLY as it appears on his/her current MAID card.~~

~~3-----M.I.~~

~~Enter the middle initial of the recipient (if listed).~~

~~4-----MEDICAL ASSISTANCE I.D. NUMBER~~

~~Enter the recipient's identification number EXACTLY as it appears on his/her current MAID card. The number consists of 10 digits and all of them must be entered. The number is the medical assistance recip~~

~~ient's social security number plus a special last digit except for refugees and temporary numbers for infants.]~~

~~5~~ ~~ACCIDENT~~

~~If the services rendered were required as the result of an accident, please check this block.~~

~~6~~ ~~HEALTH INSURANCE~~

~~If the recipient has any kind of health insurance and that insurance has made a payment for the service billed on this claim other than Medicare, enter the name and address of the insurer and the policy number. Do not enter Medicare coverage in this block.~~

~~RECIPIENT DATE OF BIRTH~~

~~Enter the recipient's date of birth in numeric format. For example, November 15, 1976 would be entered as 11 15 76 and January 16, 1976 would be entered as 01 16 76.~~

~~7~~ ~~PRIOR AUTHORIZATION~~

~~Not Applicable~~

~~8~~ ~~CATEGORY OF SERVICE~~

~~Check the box marked "other" and enter the number for Adult Day Health Care which is #53 to identify the type of provider submitting this claim.~~

~~9~~ ~~REFERRING PRACTITIONER~~

~~Not Applicable~~

~~10~~ ~~Not Applicable~~

~~11~~ ~~SCREENING RELATED SERVICES~~

~~Not Applicable]~~

~~[12] ICD-9-CM DIAGNOSIS CODE~~

~~Not Required~~

~~LEAVE BLANK - Required~~

~~Enter the ICD-9-CM diagnosis code for the diagnosis most applicable to the services rendered during the time period. Refer to Appendix VIII for a list of ICD-9-CM diagnosis codes.~~

~~13 No entry required.~~

~~14 DATE OF SERVICE~~

~~Enter the date on which each service was rendered in month, day, year sequence and in numeric format. For example, November 15, 1976 would be entered as 11 15 76 and January 16, 1976 would be entered as 01 16 76.~~

~~15 PROCEDURE/SUPPLY/DESCRIPTION~~

~~Enter a brief description of the service provided if the procedure needs additional clarification.~~

~~PROVIDER LICENSE NUMBER~~

~~Not Applicable~~

~~16 PROCEDURE/SUPPLY/CODE~~

~~Enter the HCPCS procedure code for Adult Day Health Care visit. If an ancillary service was provided, enter the HCPCS procedure code for the ancillary service. The list of HCPCS procedure codes is included with the Manual. (See Appendix IV.)~~

~~[17] UNITS OF SERVICE~~

~~Enter the number of units of service in this column. If the recipient was present in the Center for one-half day enter a 1. If the recipient was present in the Center for a whole day, enter a 2. Enter the units for the ancillary services.~~

~~18 PLACE OF SERVICE~~

~~Services for Adult Day Health Care should be marked with a 0.~~

~~19 DIAGNOSIS OR TOOTH CODE - Required~~

~~Enter a "1" or "2" according to the diagnosis being treated by the procedure.~~

~~20 FAMILY PLANNING~~

~~Not applicable to Adult Day Health Care.~~

~~21 PROCEDURE CHARGE~~

~~Enter the Center's usual and customary charge for the service provided.~~

~~22 PROFESSIONAL COMPONENT~~

~~Not applicable.~~

~~23 No entry required.~~

~~24 TOTAL CLAIM CHARGE~~

~~Enter the total of the individual procedure charges listed on lines 1-10.]~~

~~[25] HEALTH INSURANCE REIMBURSEMENTS~~

~~Enter the total amount (if any) received by you from other health insurance sources for services billed on this invoice.~~

~~26 NET CLAIM CHARGE~~

~~Subtract the amount in block 25 from the total claim charge in block 24 and enter the remainder.~~

~~27 Leave Blank. No entry.~~

~~28 PROFESSIONAL RENDERING SERVICES~~

~~Not Applicable~~

~~29 PROVIDER NUMBER~~

~~Not Applicable~~

~~30 INVOICE DATE~~

~~Enter the date in month, day, year sequence and in numeric format (e.g., 11 21 76) on which this invoice was signed and submitted to the Department for Medicaid Services for payment.]~~

~~[31] PROVIDER CERTIFICATION AND SIGNATURE~~

~~The actual signature of the provider (not a facsimile) or the provider's duly appointed representative is required.~~

~~32 PROVIDER NAME AND ADDRESS~~

~~Enter the name and address of the adult day health care center in this space.~~

~~33 PROVIDER NUMBER~~

~~Enter the 8 digit Medicaid provider number assigned to the provider indicated in block 32.~~

~~34 No entry required.~~

~~35 No entry required.~~

~~36 NAME AND ADDRESS OF HOSPITAL~~

~~Not applicable.~~

~~37 No entry required.~~

~~38 CLINIC NUMBER~~

~~Not applicable.~~

~~39 No entry required.]~~

SECTION VII - COMPLETION OF THE INVOICE FORM

2 Patient's name (Last Name, First Name, Middle Initial)

Enter the recipient's last name, first name, middle initial, if any, exactly as it appears on the Medical Assistance Identification (MAID) card.

9A Other Insured's Policy or Group Number

Enter the recipient's ten (10) digit Medical Assistance Identification Number (MAID) exactly as it appears on the recipient's MAID card.

IMPORTANT: The recipient's Kentucky Medical Assistance Identification Card shall be carefully checked to see that the recipient's name appears on the card as an eligible recipient and that the card is valid for the period of time in which the services are to be provided. You SHALL NOT be paid services provided to an ineligible person.

10 Patient's Condition

If the recipient's condition is related to employment, auto accident, or other accident, check the appropriate block.

11 Insured's Policy Group or FECA Number

If the recipient has insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim enter the policy number of the other insurance.

11C Insurance Plan Name or Program Name

If the recipient has insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim enter the name of the other insurance company.

SECTION VII - COMPLETION OF THE INVOICE FORM

21 Diagnosis or Nature of Illness or Injury

Enter the required appropriate ICD-9-CM diagnosis code.

24 Date(s) of Service

Enter the date the service(s) was provided in month, day, year numeric format, for example, 03-02-92.

24B Enter the appropriate two (2) digit place of service which identifies the location where the service was provided to the recipient. The place of service code for adult day health care service is 99.

24D Procedures, Services, or Supplies

CPT/HCPCS

Enter the appropriate procedure code identifying the service or supply provided to the recipient.

24E Diagnosis Code

Enter "1", "2", "3", "4" referencing the diagnosis for which the recipient is being treated as indicated in block 21.

24F Charges

Enter the usual and customary charge for each service being provided to the recipient.

24G Days or Units

Enter the number of units provided for the recipient on this date if service. If the recipient was present in the center for one-half day enter a 1. If the recipient was present in the center for a whole day, enter a 2. Enter the unit for the ancillary service.

SECTION VII - COMPLETION OF THE INVOICE FORM

24H EPSDT Family Plan

Enter a "Y" if the treatment provided was a direct result of an Early Periodic Screening Diagnostic and Treatment examination.

26 Patient's Account No.

Enter the patient account number, if desired. EDS will key the first seven (7) or fewer digits. This number appears on the remittance statement as the invoice number.

28 Total Charge

Enter the total of all individual charges entered in column 24F.

29 Amount Paid

Enter the amount paid, if any, by a private insurance. DO NOT ENTER MEDICARE PAID AMOUNT.

30 Balance Due

REQUIRED ONLY IF A PRIVATE INSURANCE MADE PAYMENT ON THE CLAIM. Subtract the private insurance payment entered in field 29 from the total charge entered in field 28, and enter the net balance due in field 30.

31 SIGNATURE OF PHYSICIAN OF SUPPLIER INCLUDING DEGREES OR CREDENTIALS

The actual signature of the provider (not a facsimile) or the provider's duly appointed representative is required. Stamped signatures are not acceptable.

Date

Enter the date the claim is submitted in a month, day, year numeric format, such as 03-21-92. This date must be on or after the date(s) of service billed on the claim.

SECTION VII - COMPLETION OF THE INVOICE FORM

33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND
PHONE NUMBER

Enter the provider's name, address, zip code, and phone number.

PIN #

Enter the eight (8) digit individual Kentucky Medicaid provider
number.

D. Billing Instructions for Claims with Service Dates Over one (1) Year
Old

Medicaid claims shall be filed within one year of the date of ser-
vice. Medicaid and Medicare crossovers shall be filed within one
year of the date of service OR within six months of the Medicare
Paid Date, whichever is longer. To process claims beyond this limit
you shall attach, to EACH claim form involved, a copy of an in-pro-
cess or denied claim remittance, no more than 12 months of age,
which verifies that the original claim was submitted within 12
months of the service date.

Copies of previously submitted claim forms, providers' in-house
records of claim submittal, letters which merely detail filing dates
are NOT acceptable documentation of timely billing. Attachments
must prove that the claim was RECEIVED timely by EDS.

If a claim is being submitted after twelve months from the date of
service, due to the recipient's retroactive eligibility, a copy of
the backdated or retroactive MAID card shall be attached to the in-
voice.

Please note on the claim the words "Backdated Eligibility" or "Retro-
active Eligibility."

SECTION VII - COMPLETION OF THE INVOICE FORM

E. Electronic Media Claims

Electronic Media Claims (EMC) is a means by which Adult Day Health Care providers may submit claims electronically. EMC enables providers to experience an improved cash flow, fewer errors in claims processing, and a reduction in effort with claim preparation. Claims may be submitted electronically in a variety of different ways such as via magnetic tape, diskette, or modem.

Claims that require attachments shall not be submitted electronically.

For more information regarding EMC, contact an EMC Representative at (502) 227-9073 or 1-800-756-7557. You may also write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602.

SECTION VIII - REMITTANCE STATEMENT

VIII. REMITTANCE STATEMENT

A. General Information

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS Federal Corporation processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by Medicaid [~~the KMAP~~] with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by Medicaid [~~the KMAP~~] with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of the EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

SECTION VIII - REMITTANCE STATEMENT

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix VII P.1. This section lists all those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR
ADULT DAY HEALTH CARE SERVICES

ITEM	DEFINITION
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS Federal Corporation.
CLAIM SVC DATE	The earliest and latest date of services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for the services on this claim form.
CHARGES NOT COVERED	Any portion of the provider's billed charges that are not being paid (examples: rejected line item, reduction in billed amount to allowed charge).

SECTION VIII - REMITTANCE STATEMENT

AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
LINE NO.	The number of the line on the claim being printed.
PS	Place of service code depicting the location of the rendered service.
PROC	The HCPCS procedure code in the line item.
QTY	The number of procedures/supply for that line item charge.
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item.
LINE ITEM PMT	The amount being paid by the Medicaid program to the provider for a particular line item.
EOB	Explanation of benefit code which identifies the payment process used to pay the line item.

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all such claims and indicates the EOB code explaining the reason for each claim rejection. Appendix VII P.2.

All items printed have been previously defined in the description of the paid claims section of the Remittance Statement.

SECTION VIII - REMITTANCE STATEMENT

D. Section III - Claim in Process

The third section of the Remittance Statement (Appendix VII P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of date errors or the need for further review. A claim appears in the Claims In Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statements (Appendix VII P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and the year-to-date (YTD) claims payment activities.

CLAIMS PAID/
DENIED

The total number of finalized claims which have been determined to be denied or paid by the Medicaid program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.

AMOUNT PAID

The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.

SECTION VIII - REMITTANCE STATEMENT

WITHHELD AMOUNT	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies).
NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix VII P.5).

SECTION IX - GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

TYPE OF INFORMATION REQUESTED	TIME FRAME FOR INQUIRY	MAILING ADDRESS
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Provider Relations
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Financial Services [Cash/Finance Unit]

TYPE OF INFORMATION REQUESTED	NECESSARY INFORMATION
Inquiry	<ol style="list-style-type: none">1. Completed Inquiry Form2. Remittance Advice or Medicare EOMB, when applicable3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on a RA <u>Remittance Advice</u> [R/A] within a reasonable amount of time

SECTION IX - GENERAL INFORMATION - EDS

TYPE OF
INFORMATION
REQUESTED

NECESSARY INFORMATION

Adjustment

1. Completed Adjustment Form
2. Corrected [~~Photocopy of the~~] claim [~~in ques-~~
~~tion~~]
3. Photocopy of the applicable portion of the
Remittance Advice [~~R/A~~] in question

Refund

1. Refund Check
2. Cash Refund Documentation Form
3. [~~2.~~] Photocopy of the applicable portion of the
Remittance Advice [~~R/A~~] in question
4. [~~3.~~] Reason for refund

B. Telephoned Inquiry Information

WHAT IS NEEDED?

- Provider number
- Patient's Medicaid ID number
- Date of service
- Billed amount
- Your name and telephone number

WHEN TO CALL?

- When claim is not showing on paid, pending or denied sections of
the Remittance Advice [~~R/A~~] within 6 weeks
- When the status of claims is [are] needed and they do not exceed
five in number

WHERE TO CALL?

- Toll-free number 1-800-756-7557 [~~333-2188~~] (within Kentucky)
- Local (502) 227-2525

SECTION IX - GENERAL INFORMATION - EDS

C. Filing Limitations

New Claims - 12 months from date of service

Medicare/Medicaid - 12 months from date of service

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.

Third-Party Liability Claims - 12 months from date of service

NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

Adjustments - 12 months from date the paid claim appeared on the Remittance Advice [R/A].

SECTION IX - GENERAL INFORMATION - EDS

D. Provider Inquiry Form

The Provider Inquiry Form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry Form should be completed for each status request.) The Provider Inquiry form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry Form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-800-~~[333-2188]~~ 756-7557 or 1-(502)-227-2525.

Please remit BOTH copies of the Provider Inquiry Form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is NOT necessary to complete a Provider Inquiry Form when resubmitting a denied claim.

Provider Inquiry Forms may NOT be used in lieu of the Medicaid [KMAP] Claim Forms, Adjustment Forms, or any other document required by the Medicaid program [KMAP].

In certain cases it may be necessary to return the Inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry Form are found on the next page.

SECTION IX - GENERAL INFORMATION - EDS

Following are field by field instructions for completing the Provider Inquiry Form:

FIELD NUMBER	INSTRUCTIONS
1	Enter your 8-digit Kentucky Medicaid Provider Number. [If you are a KMAP certified clinic, enter your 8-digit clinic number.]
2	Enter your Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit <u>Medicaid</u> [Medical As- sistance] ID number.
5	Enter the billed amount of the claim on which you are inquiring.
6	Enter the claim service date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13-digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and the date of the inquiry.

SECTION IX - GENERAL INFORMATION - EDS

E. Adjustment Request Form Instructions

The Adjustment Request Form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CORRECTED CLAIM AND THE APPROPRIATE PAGE OF THE REMITTANCE ADVICE [R/A] MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

FIELD NUMBER	DESCRIPTION
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the <u>Remittance Advice [R/A]</u> (last name first).
3	Enter the complete recipient identification number as it appears on the <u>Remittance Advice [R/A]</u> . The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.

SECTION IX - GENERAL INFORMATION - EDS

FIELD NUMBER	DESCRIPTION
8	Enter the total Medicaid payment for the claim as found under the "Claims Payment Amount" column on the <u>Remittance Advice</u> [R/A].
9	Enter the <u>Remittance Advice</u> [R/A] date which is found on the top left corner of the remittance. Please do not enter the date the payment we received or posted.
10	Specifically state WHAT is to be adjusted on the claim (i.e. date of service, units of service).
11	Specifically state the reasons for the request adjustment (i.e. miscoded, overpaid, underpaid).
12	Enter the name of the person who completed the Adjustment Request Form.
13	Enter the date on which the form was submitted.

Mail the completed Adjustment Request Form, claim copy and Remittance Advice to the address on the top of the form.

To reorder these forms, contact the Provider Relations Unit:

EDS
P.O. Box 2009
Frankfort, KY 40602

Be sure to specify the number of forms you desire. Allow 7 days for delivery.

The provider may obtain copies of these forms by calling EDS at (502) 227-9073 or 1-800-756-7557.

SECTION X - GENERAL INFORMATION - EDS

F. Cash Refund Documentation

The Cash Refund Documentation Form shall be completed when a provider sends a refund check. The completed form and a copy of the Remittance Statement page showing the paid claim being refunded should accompany the check. Please mail to the following address:

EDS
P.O. Box 2009
Attn: Financial Services
Frankfort, KY 40602

If a check is sent without the Cash Refund Documentation Form, your check will not be posted to a specific claim. Such action would not reflect the refund being made for a particular claim, possibly leaving the provider responsible for another refund at a later date. If there are any questions concerning the form, please call the Provider Relations Unit at 1-800-756-7557 or 1-(502)-227-2525.

<u>Field Number</u>	<u>Description</u>
<u>1</u>	<u>Enter check number</u>
<u>2</u>	<u>Enter amount of the check</u>
<u>3</u>	<u>Enter provider name, number and address</u>
<u>4</u>	<u>Enter name of recipient on claim being refunded</u>
<u>5</u>	<u>Enter recipient's Medicaid identification number (10 numeric digits)</u>
<u>6</u>	<u>Enter "From Date of Service" on claim being refunded</u>
<u>7</u>	<u>Enter "To Date of Service" on claim being refunded</u>
<u>8</u>	<u>Enter date of the paid Remittance Statement on which the claim appears</u>
<u>9</u>	<u>Enter 13-digit Internal Control Number (ICN) of the particular claim for which you are refunding. This is listed on</u>

SECTION X - GENERAL INFORMATION - EDS

the "Paid Claims" page of your Remittance Statement. (If several ICN's are to be applied to one check, they can be listed on the same form only if they have the same reason for refund explanation (see below).

REASON FOR REFUND

Check the appropriate reason for which the claim is being refunded. Be sure to complete all blanks. The example listed below shows how each refund is to be completed accurately. Only one reason can be completed per Cash Refund Documentation Form. If multiple claims with multiple refund reasons are included in one check, complete a separate form for each refund reason.

- a. Payment from other source - Check the category and list name (attach a copy of EOB)

Health Insurance
Auto Insurance
Medicare paid
Other

Worker's Comp-ABC Construction

- b. Billed in error

- c. Duplicate payment (attach a copy of both Remittance Statement) If Remittance Statement are paid to 2 different providers specify to which provider number the check is to be applied

1 2 3 4 5 6 7 8

- d. Processing error or Overpayment

Explain why Processing error-wrong date of service was keyed

- e. Paid to wrong provider

- f. Money has been requested - date of letter 1-1089 (Attach a copy of letter requesting money)

SECTION X - GENERAL INFORMATION - EDS

g. Other

Medicare made an adjustment. Deductible no longer due

Contact Name:

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ADULT DAY HEALTH CARE SERVICES MANUAL

DEPARTMENT FOR MEDICAID SERVICES
[KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES]

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services performed in ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to recipients under age twenty-one (21). [Coverage is limited but includes X-rays, fillings, simple extractions, and emergency treatment for pain, infection and hemorrhage. Preventive dental care is stressed for individuals under age 21.]

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-second birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

Medical History
Physical Examination
Growth and Development Assessment
Hearing, Dental, and Vision Screenings
Lab tests as indicated
Assessment or Updating of Immunizations

CABINET FOR HUMAN RESOURCES
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FAMILY PLANNING SERVICES

Comprehensive family planning services shall be ~~[are]~~ available to all eligible Medicaid ~~[Title XIX]~~ recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be ~~[are]~~ available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be ~~[are]~~ provided.

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be ~~[are]~~ paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall ~~[are]~~ also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aide services shall be ~~[are]~~ covered when necessary to help the patient remain at home. Medical social worker services shall be ~~[are]~~ covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall ~~[is]~~ not be limited by age.

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DEPARTMENT FOR MEDICAID SERVICES
[~~KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES~~]

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid [~~KMAP~~] benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall [~~must~~] be preauthorized by a Peer Review Organization. Certain surgical procedures shall [~~are~~] not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medical necessity requiring admission to the hospital. Elective and cosmetic procedures shall be [~~are~~] outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be [~~is~~] limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

OUTPATIENT SERVICES

Benefits of this Program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals covered, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be [~~are~~] no limitations on the number of hospital outpatient visits or covered services available to Medicaid [~~program~~] recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid [~~Medical Assistance Program KMAP~~] participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

DEPARTMENT FOR MEDICAID SERVICES
[~~KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES~~]

LONG TERM CARE FACILITY SERVICES

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (ICF/MR/DD)

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

~~[LONG TERM CARE FACILITY SERVICES]~~

~~SKILLED NURSING FACILITY SERVICES~~

~~The KMAP can make payment to skilled nursing facilities for:~~

- ~~A. Services provided to Medicaid recipients who require twenty-four (24) skilled nursing care and/or skilled services which as a practical matter can only be provided on an inpatient basis~~
- ~~B. Services provided to recipients who are also medically eligible for Medicare benefits in the skilled nursing facility.~~

~~-Coinsurance from the 21st through the 100th day of this Medicare benefit period.~~

~~-Full cost for the full length of stay after the 100th day if 24-hour skilled nursing care is still required~~

~~*Need for skilled nursing care must be certified by a Peer Review Organization (PRO).]~~

~~[INTERMEDIATE CARE FACILITY SERVICES]~~

~~The KMAP can make payment to intermediate care facilities for:~~

- ~~A. Services provided to recipients who require intermittent skilled nursing care and continuous personal care supervision~~
- ~~B. Services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age 22, who because of their mental and physical condition require care and services which are not provided by community resources~~

The need for the ICF/MR/DD [intermediate] level of care [and the ICF/MR/DD level of care] shall [must] be certified by the Kentucky Medicaid Peer Review Organization (PRO).

MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be [are] provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be [is] no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES
[~~KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES~~]

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

Outpatient Services
Psychosocial Rehabilitation
Emergency Services
Inpatient Services
Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health center and possibly avoid hospitalization. There are fourteen (14) major centers, with many satellite centers available. The Kentucky Medicaid [Medical Assistance] Program also reimburses psychiatrists for psychiatric services through the physician program.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be ~~[are]~~ covered by the Kentucky Medicaid Program [KMAP].

NURSE MIDWIFE SERVICES

Medicaid coverage shall be ~~[is]~~ available for services performed by a participating Advanced Registered Nurse Practitioner - Nurse Midwife. Covered services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up post partum visits within four (4) to six (6) weeks of the delivery date.

NURSE PRACTITIONER

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure.

DEPARTMENT FOR MEDICAID SERVICES
[~~KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES~~]

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be ~~[are]~~ covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed periodically ~~[quarterly]~~ with monthly updates. ~~[In addition]~~ Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be ~~[are]~~ covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall ~~[must]~~ be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs, selected vaccines and Rhogam), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

ADULT DAY HEALTH CARE SERVICES MANUAL

DEPARTMENT FOR MEDICAID SERVICES
[KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES]

Limited coverage:

Certain types of office exams, such as comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

~~The following laboratory procedures are covered when performed in the office by an M.D. or osteopath.~~

Ova and Parasites (feces)	Bone Marrow spear and/or cell block;
Smear for Bacteria, stained	aspiration only
Throat Cultures (Screening)	Smear; interpretation only
Red Blood Count	Aspiration; staining and interpretation
Hemoglobin	Aspiration and staining only
White Blood Count	Bone Marrow needle biopsy
Differential Count	Staining and interpretation
Bleeding Time	Interpretation Only
Electrolytes	Fine needle aspiration with or without
Glucose Tolerance	preparation of smear; superficial tissue
Skin Tests for:	Deep tissue with radiological guidance
Histoplasmosis	Evaluation of fine needle aspirate with or
Tuberculosis	without preparation of smears
Coccidioidomycosis	Duodenal intubation and aspiration: single
Mumps	specimen
Brucella	Multiple specimens

~~PHYSICIAN SERVICES (Continued)~~

Complete Blood Count	Gastric intubation and aspiration: diagnostic
Hematocrit	Nasal smears for eosinophils
Prothrombin Time	Sputum, obtaining specimen, aerosol induced
Sedimentation Rate	technique
Glucose (Blood)	
Blood Urea Nitrogen (BUN)	
Uric Acid	
Thyroid Profile	
Platelet count	
Urine Analysis	
Creatinine	

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be ~~[are]~~ covered by the Kentucky Medicaid [Medical Assistance] Program. Routine foot care shall be ~~[is]~~ covered only for certain medical conditions where the ~~[such]~~ care requires professional supervision.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be ~~[are]~~ generally applicable when the services are provided by a primary care center.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment services must be verified through the utilization control mechanism. RENAL DIALYSIS CENTER SERVICES

CABINET FOR HUMAN RESOURCES
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DEPARTMENT FOR MEDICAID SERVICES

RENAL DIALYSIS CENTER SERVICES

Free-standing renal dialysis center service benefits include renal dialysis, certain supplies and home equipment.

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasizes preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall ~~[must]~~ also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

~~[SCREENING SERVICES]~~

~~Through the screening service element, eligible recipients, age 0 thru birth month of 21st birthday, may receive the following tests and procedures as appropriate for age and health history when provided by participating providers.]~~

[Medical History	Tuberculin Skin Test
	Physical Assessment	Dental Screening
	Growth and Developmental Assessment	Screening for Venereal Disease,
	Screening for Urinary Problems	As Indicated
	Screening for Hearing and	Assessment and/or Updating
	Vision Problems	of Immunizations]

TRANSPORTATION SERVICES

Medicaid shall ~~[may]~~ cover transportation to and from Medicaid Program ~~[Title XIX]~~ covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be ~~[is]~~ preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall ~~[is]~~ not be covered.

ADULT DAY HEALTH CARE SERVICES MANUAL

DEPARTMENT FOR MEDICAID SERVICES
[KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP) SERVICES]

VISION SERVICES

Examinations and certain diagnostic procedures performed by optometrists shall be ~~[are]~~ covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be ~~[are]~~ covered for eligible recipients under age twenty-one (21).

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health departments or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

**** SPECIAL PROGRAMS****

KENPAC: The Kentucky Patient Access and Care System, or KenPAC, is a special program which links the recipient with a primary physician or clinic for many Medicaid-covered services. Only recipients who receive assistance based on Aid to Families with Dependent Children (AFDC) or AFDC-related Medical Assistance Only shall be covered under KenPAC. The recipient shall ~~[may]~~ choose the physician or clinic. It is especially important for the KenPAC recipient to present his or her Medical Assistance Identification Card each time a service is received.

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

AIS/MR: The Alternative Intermediate Services for the ~~[A]~~ Mentally Retarded ~~[ation]~~ (AIS/MR) home- and community-based services project provides coverage for an array of community based services that shall be ~~[is]~~ an alternative to receiving the services in an intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD). ~~[Community mental health centers arrange for and provide these services.]~~

ADULT DAY HEALTH CARE SERVICES MANUAL

DEPARTMENT FOR MEDICAID SERVICES

HOME- AND COMMUNITY- BASED WAIVER SERVICES

~~[HCB-]~~ A Home- and Community- Based Services program project provides Medicaid coverage for a broad array of Home- and Community- Based Services for elderly and disabled recipients. These services shall be available to recipients who would otherwise require the services in a nursing facility. (SNF) Skilled Nursing Facility or (ICF) Intermediate Care Facility. The services became available are statewide effective July 1, 1987. These services shall be arranged for and provided by Home Health Agencies.

SPECIAL HOME- AND COMMUNITY- BASED SERVICES MODEL WAIVER PROGRAM

The Model Waiver Services Program provides up to sixteen (16) hours of private duty nursing services and respiratory therapy services to disabled ventilator dependent Medicaid recipients who would otherwise require the level of care provided in a hospital-based skilled nursing facility. This program shall be limited to no more than fifty (50) recipients.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall ~~[are]~~ also be provided to the patient and ~~[his/her]~~ family in adjustment to the patient's illness and death. A Medicaid recipient ~~[client]~~ who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall ~~[are]~~ also be included in the hospice care scope of benefits.

~~[TARGETED CASE MANAGEMENT SERVICES]~~

~~Comprehensive case management services shall be provided to handicapped or impaired Medicaid-eligible children under age 21 who also meet the eligibility criteria of the Commission for Handicapped Children, the State's Title V Crippled Children's Agency. Recipients of all ages who have hemophilia may also qualify.]~~

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

AFDC (Aid to Families with Dependent Children)

AFDC Related Medical Assistance

State Supplementation of the Aged, Blind, or Disabled

Aged, Blind, or Disabled Medical Assistance

~~[Refugee Resettlement Programs]~~

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits should be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office for information about making application. For most programs, a relative or other interested party may make application for a person unable to visit the office.

In addition to the program administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) program also receive Medicaid through the Kentucky Medical Assistance Program. Eligibility for SSI is determined by the Social Security Administration. Person wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live. The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend-down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend-down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend-down" eligibility period.

MAID cards may show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals whose original card is lost or stolen. The recipient should report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

APPENDIX II-A

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
"From" date is first day of eligibility of this card.
"To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES				Members Eligible for Medical Assistance— Benefits	Medical Assistance Identification Number	DATE OF BIRTH MO-YR	SEX	AGE
ELIGIBILITY PERIOD		CASE NUMBER						
FROM:	08-01-88							
TO:	07-01-89		037 C 000123456					
CASE NAME AND ADDRESS								
ISSUE DATE: 05-27-88 Jane Smith 400 Block Ave. Frankfort, KY 40601				Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS								
SEE OTHER SIDE FOR SIGNATURE								

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P.
Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "ins." block.

This card certifies that the person(s) listed herein is/are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, payments paid, or third party liability, should be directed to:
Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Charous |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and/or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipients temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 225.024 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf. Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance able to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of KMAP eligibility represented by this card.
"From" date is first day of eligibility of this card.
"To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

NOTICE
QMB
Info.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD FROM: 08-01-88 TO: 07-01-89 CASE NUMBER 037 C 000123456		... THIS PERSON IS ALSO ELIGIBLE FOR QMB BENEFITS ...			
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane Smith, Km	1234567890 2345678912	2 0353 2 1284	M M
ISSUE DATE: 05-27-88					
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS					
SEE OTHER SIDE FOR SIGNATURE		MAP 888 REV 088			

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For K.M.A.P.
Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for K.M.A.P. benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-8
(cont.)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

This card certifies that the persons listed herein are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.

Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources
Department for Social Insurance
Division of Medical Assistance
Frankfort, KY 40621

Insurance Identification

- | | |
|--|-----------------------------------|
| A Part A Medicare Only | G Charms |
| B Part B Medicare Only | H Health Maintenance Organization |
| C Both Parts A & B Medicare | J Other and/or Unknown |
| D Blue Cross Blue Shield | L Absent Parent's Insurance |
| E Blue Cross Blue Shield Major Medical | M None |
| F Private Medical Insurance | N United Mine Workers |
| | P Black Lung |

RECIPIENT OF SERVICES

1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, obstetrics, non-emergency transportation, screening, and family planning services.
2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.
3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.
4. If you have questions, contact your eligibility worker at the county office.
5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance.

Signature

RECIPIENT OF SERVICES: You are hereby notified that under State Law 1976 256 024 you agree to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf. Federal law provides for a \$100,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance with the intent to report charges relating to eligibility or persons use of the card by an ineligible person.

Notification to recipient of assignment
to the Cabinet for Human Resources of
third party payments.

Recipient's signature is not required.



QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of QMB eligibility represented by this card.
* From* date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Medical Insurance Code indicates type of insurance coverage.

 		
LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ELIGIBLE RESIDENT AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601	ELIGIBILITY PERIOD FROM: TO: MEDICAID CARD ID. NO. SEX CODE MEDICAL INSURANCE ID. DATE OF BIRTH MONTH YEAR	COVERAGE IS LIMITED TO: <ul style="list-style-type: none"> * MEDICARE PART B PREMIUMS * MEDICARE CO-INSURANCE * MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION PLEASE SIGN IMMEDIATELY
ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE		
MAP 120-C REV 11-88		

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through QMB.

PROVIDER OF SERVICE	RECIPIENT OF SERVICES														
<p>1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductibles only.</p> <p>2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p>Cabinet for Human Resources Department for Medicaid Services 275 East Main Street Frankfort, KY 40621-0001</p>	<p>1. Show this card whenever you receive medical care.</p> <p>2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.</p> <p>3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>4. If you have questions, contact your case worker at the Department for Social Insurance County office.</p>														
<p>Insurance Identification</p> <table><tbody><tr><td>A—Part A, Medicare Only</td><td>G—Champus</td></tr><tr><td>B—Part B, Medicare Only</td><td>H—Health Maintenance Organization</td></tr><tr><td>C—Both Parts A & B Medicare</td><td>J—Other and / or Unknown</td></tr><tr><td>D—Blue Cross /Blue Shield</td><td>L—Absent Parents Insurance</td></tr><tr><td>E—Blue Cross /Blue Shield Major Medical</td><td>M—None</td></tr><tr><td>F—Private Medical Insurance</td><td>N—United Mine Workers</td></tr><tr><td></td><td>P—Black Lung</td></tr></tbody></table>	A—Part A, Medicare Only	G—Champus	B—Part B, Medicare Only	H—Health Maintenance Organization	C—Both Parts A & B Medicare	J—Other and / or Unknown	D—Blue Cross /Blue Shield	L—Absent Parents Insurance	E—Blue Cross /Blue Shield Major Medical	M—None	F—Private Medical Insurance	N—United Mine Workers		P—Black Lung	
A—Part A, Medicare Only	G—Champus														
B—Part B, Medicare Only	H—Health Maintenance Organization														
C—Both Parts A & B Medicare	J—Other and / or Unknown														
D—Blue Cross /Blue Shield	L—Absent Parents Insurance														
E—Blue Cross /Blue Shield Major Medical	M—None														
F—Private Medical Insurance	N—United Mine Workers														
	P—Black Lung														
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law KRS 205.634 your right to third party payment has been assigned to the Cabinet for the amount of medical services and on your card.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>															

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

APPENDIX II-D

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care physician listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for KMAP. Persons whose names are in this block have the Primary Care provider listed on this card.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance - Benefits	Medical Assistance Identification Number	AGE	DATE OF BIRTH MO/YR	SEX
ELIGIBILITY PERIOD FROM: 06-01-88 TO: 07-01-88		CASE NUMBER 037 C 000123456				
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane Smith, Kim		1234567890 2345678912	2 0353 2 1284	M M
ISSUE DATE: 06-27-88						
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		KENPAC PROVIDER AND ADDRESS Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 502-348-9832 PHONE				
SEE OTHER SIDE FOR SIGNATURE		MAP CASE #000				

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care Physician.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

**APPENDIX II-D
(cont.)**

KENTUCKY PATIENT ACCESS AND CARE (KENPAC) SYSTEM CARD

(BACK OF CARD)

Information to Providers, including insurance identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDER OF SERVICE		RECIPIENT OF SERVICE														
<p>This card certifies that the person listed herein is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to section (1) and (2) under "Recipient of Service."</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621</p>		<p>1. The designated KenPAC primary provider must provide or authorize the following services: physician, licensed therapist and sub-provider, nurse health officer, laboratory, ambulatory surgical center, ambulatory care center, dental health center, and durable medical equipment. Authorization by the primary provider is not required for services provided by certified therapists or licensed clinical psychologists, for educational services provided by an occupation or occupational therapist, or for other covered services not listed above.</p> <p>2. In the event of an emergency, payment can be made to a participating medical provider rendering services to this person, if it is a covered service, without prior authorization of the primary provider listed on the reverse side.</p> <p>3. Covered services which may be obtained without prior authorization from the KenPAC primary provider include services from pharmacists, community-based health centers, nursing homes, intermediate care facilities, mental hospitals, foster families, and participating providers of dental, hearing, vision, ambulatory, non-emergency transportation, counseling, family planning services, and fertility services.</p> <p>4. Show this card to the person who provides these services to you whenever you receive medical care.</p> <p>5. You will receive a new card at the end of each month as long as you are eligible for benefits. For your protection, please sign on the top below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>6. If you have questions, contact your eligibility worker at the county office.</p> <p>7. Remember that temporarily that all of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.</p>														
<p>Insurance Identification</p> <table border="0"> <tr> <td>A—Part A, Medicare Only</td> <td>G—Cherokee</td> </tr> <tr> <td>B—Part B, Medicare Only</td> <td>H—Health Maintenance Organization</td> </tr> <tr> <td>C—Both Parts A & B Medicare</td> <td>J—Other and / or Unknown</td> </tr> <tr> <td>D—Blue Cross / Blue Shield</td> <td>L—Absent Parent's Insurance</td> </tr> <tr> <td>E—Blue Cross / Blue Shield Major Medical</td> <td>M—None</td> </tr> <tr> <td>F—Private Medical Insurance</td> <td>N—United Mine Workers</td> </tr> <tr> <td></td> <td>P—Black Lung</td> </tr> </table>		A—Part A, Medicare Only	G—Cherokee	B—Part B, Medicare Only	H—Health Maintenance Organization	C—Both Parts A & B Medicare	J—Other and / or Unknown	D—Blue Cross / Blue Shield	L—Absent Parent's Insurance	E—Blue Cross / Blue Shield Major Medical	M—None	F—Private Medical Insurance	N—United Mine Workers		P—Black Lung	<p>Signature _____</p>
A—Part A, Medicare Only	G—Cherokee															
B—Part B, Medicare Only	H—Health Maintenance Organization															
C—Both Parts A & B Medicare	J—Other and / or Unknown															
D—Blue Cross / Blue Shield	L—Absent Parent's Insurance															
E—Blue Cross / Blue Shield Major Medical	M—None															
F—Private Medical Insurance	N—United Mine Workers															
	P—Black Lung															
<p>RECIPIENT OF SERVICE: You are hereby notified that under State Law 1976 205.024 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance due on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes resulting in eligibility, or permits use of the card by an ineligible person.</p>																

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

**CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES**

APPENDIX II-E

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (MAID.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services on the claim form.

Name and provider number of Lock-in physician. KMAP payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the KMAP).

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		ELIGIBILITY PERIOD		PHYSICIAN NAME	
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		FROM			
ELIGIBLE RECIPIENT & ADDRESS		TO		PHYSICIAN PROVIDER NO.	
		MEDICAL ASSISTANCE IDENTIFICATION NUMBER			
		SEX CODE			
		INSURANCE		PHARMACY NAME	
		DATE OF BIRTH MONTH YEAR		PHARMACY PROVIDER NO.	
		CASE NUMBER			
SEE OTHER SIDE FOR SIGNATURE		MAP 888A REV 11/88			

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-in pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

APPENDIX II-E
(cont.)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services; however, payment can only be made within the scope of Program benefits. Recipients temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Division of Medical Assistance. Questions regarding scope of services should be directed to the Lock-In coordinator by calling 606-664-6822.

You are hereby notified that under State Law KRS 205.624 your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

INSURANCE INFORMATION

- A Part A Medicare Only
- B Part B Medicare Only
- C Both Parts A & B Medicare
- D Blue Cross Blue Shield
- E Blue Cross Blue Shield Major Medical
- F Private Medical Insurance

- G Charities
- H Health Maintenance Organization
- J Other and/or Unknown
- L Absent Parent's Insurance
- M None
- N United Mine Workers
- P Black Lung

I have read the above information and agree with the procedures as outlined and explained to me.

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance failure report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

- (a) name;
- (b) ownership;
- (c) licensure/certification/regulation status; or
- (d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19____, with conditional termination on _____, 19____, and shall automatically terminate on _____, 19____, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

NAME: _____

TITLE: _____

DATE: _____

MAP-344 (Rev. 3/91)

Kentucky Medicaid Program

Provider Information

1. _____
(Name) _____ (County)
2. _____
(Location Address, Street, Route No, P.O. Box)
3. _____
(City) _____ (State) _____ (Zip)
4. _____
(Office Phone# of Provider)
5. _____
(Pay to, In care of, Attention, etc. If different from above address.)
6. _____
Pay to address (If different from above)
7. Federal Employee ID No. _____
8. Social Security No. _____
9. License No. _____
10. Licensing Board (If applicable): _____
11. Original license date: _____
12. Kentucky Medicaid Provider No. (If known) _____
13. Medicare Provider No. (If applicable) _____
14. Practice Organization/Structure: _____ (1) Corporation
_____ (2) Partnership _____ (3) Individual
_____ (4) Sole Proprietorship _____ (5) Public Service Corporation
_____ (6) Estate/Trust _____ (7) Government/Non-Profit
15. Are you a hospital based physician (salaried or under contract
by a hospital)? _____ yes _____ no
Name of hospital(s) _____

16. If group practice, number of providers in group (specify provider type):

17. If corporation, name, address, and telephone number of corporate office:

Telephone No: _____

Name and address of officers:

18. If partnership, name and address of partners:

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:

___ Federal ___ State ___ County ___ City

___ Charitable or religious

___ Proprietary (Privately-owned) ___ Other

NEW FORM

APPENDIX III

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board:

Member: _____

Member: _____

30. Management Firm (If applicable):

31. Lessor (If applicable):

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership
------	---------	----------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

34. Institutional Review Committee Members (If applicable):

35. Providers of Transportation Services:

Number of Ambulances in Operation: _____

Number of Wheelchair Vans in Operation: _____

Basic Rate \$ _____ (Includes up to _____ miles)

Per Mile \$ _____ Oxygen \$ _____

Extra Patient \$ _____ Other \$ _____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? _____ yes _____ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

Date: _____ Staff: _____

MAP-344 (Rev. 08/85)

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Information

1. Name: _____
 2. _____
Street Address, P.O. Box, Route Number (In Care of, Attention, etc.)
 3. _____
City State Zip Code
 4. _____
Area Code Telephone Number
 5. _____
Pay to, In Care of, Attention, etc. (If different from above)
 6. _____
Pay to Address (If different from above)
 7. Federal Employer ID Number: _____
 8. Social Security Number: _____
 9. License Number: _____
 10. Licensing Board (If Applicable): _____
 11. Original License Date: _____
 12. KMAP Provider Number (If Known): _____
 13. Medicare Provider Number (If Applicable): _____
 14. Provider Type of Practice Organization:

<input type="checkbox"/> Corporation (Public)	<input type="checkbox"/> Individual Practice	<input type="checkbox"/> Hospital-Based Physician
<input type="checkbox"/> Corporation (Private)	<input type="checkbox"/> Partnership	<input type="checkbox"/> Group Practice
<input type="checkbox"/> Health Maintenance Organization	<input type="checkbox"/> Profit	<input type="checkbox"/> Non-Profit
- If group practice, Number of Providers in Group (specify provider type):

OLD FORM

16. If corporation, name, address and telephone number of Home Office:

Name: _____

Address: _____

Telephone Number: _____

Name and Address of Officers:

17. If Partnership, name and address of Partners:

18. National Pharmacy Number (If Applicable):

(Seven-Digit Number Assigned by
National Pharmaceutical Association)

19. Physician/Professional Specialty:

1st _____

2nd _____

3rd _____

20. Physician/Professional Specialty Certification:

1st _____

2nd _____

3rd _____

Physician/Professional Specialty Certification Board:

1st _____ Date: _____
 2nd _____ Date: _____
 3rd _____ Date: _____

22. Name of Clinic(s) in which Provider is a Member:

1st _____
 2nd _____
 3rd _____
 4th _____

23. Control of Medical Facility:

☐ Federal ☐ State ☐ County ☐ City ☐ Charitable or Religious
☐ Proprietary (Privately owned) ☐ Other _____

24. Fiscal Year End: _____

Administrator: _____ Telephone No. _____

26. Assistant Administrator: _____ Telephone No. _____

27. Controller: _____ Telephone No. _____

28. Independent Accountant or CPA: _____ Telephone No. _____

29. If sole proprietorship, name, address, and telephone number of owner:

Name: _____
 Address: _____
 Telephone No. _____

30. If facility is government owned, list names and addresses of board members:

	Name	Address
President or Chairman of Board:	_____	_____
Member:	_____	_____
Member:	_____	_____
Member:	_____	_____
Member:	_____	_____

OLD FORM

31. Management Firm (If Applicable):

Name: _____

Address: _____

32. Lessor (If Applicable):

Name: _____

Address: _____

33. Distribution of Beds in Facility (Complete for all levels of care):

	<u>Total Licensed Beds</u>	<u>Total Title XIX Certified Beds</u>
Hospital Acute Care	_____	_____
Hospital Psychiatric	_____	_____
Hospital TB/Upper Respiratory Disease	_____	_____
Skilled Nursing Facility	_____	_____
Intermediate Care Facility	_____	_____
ICF/MR/DD	_____	_____
Personal Care Facility	_____	_____

34. SNF, ICF, ICF/MR/DD Owners with 5% or More Ownership:

<u>Name</u>	<u>Address</u>	<u>Percent of Ownership</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAP-344 (Rev. 08/85)

35. Institutional Review Committee Members (If Applicable):

36. Providers of Transportation Services:

No. of Ambulances in Operation: _____ No. of Wheelchair Vans in Operation: _____
 Total No. of Employees: _____ (Enclose list of names, ages, experience & Training.)

Current Rates:

A. Basic Rate \$ _____ (Includes up to _____ miles.)
 B. Per Mile \$ _____
 C. Oxygen \$ _____ E. Other _____
 D. Extra Patient \$ _____ \$ _____

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medical Assistance Program.

Signature: _____

Name: _____

Title: _____ Date: _____

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments: _____

Date: _____ Staff: _____

NEW FORM

APPENDIX III

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

NEW FORM

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,

Name and Address of Provider

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

(Type of Provider and/or Level of Care)

(Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

- A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.
- B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.
- C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

NEW FORM

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Page 2

APPENDIX IV

- D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.
 - E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.
 - F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.
 - G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.
2. The Cabinet:
- A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.
 - B. Agrees to assign to the provider or its agent a code to enable the media to be processed.
 - C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Provider

BY: _____
Signature of Authorized Official
or Designee

Contact Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

(MAP-380, 11/86)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

PROVIDER AGREEMENT ADDENDUM

This addendum to the Provider Agreement, is made and entered into as of the _____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____

Name and Address of Provider
hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider participates in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

(Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(A) Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

(B) Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

(C) Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable laws."

OLD FORM

(D) Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

(E) Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

(F) Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

2. The Cabinet:

(A) Agrees to accept electronic media claims for the services performed by this provider and to reimburse the provider in accordance with established policies.

(B) Agrees to assign to the provider or its agent a code to enable the media to be processed.

Either party shall have the right to terminate this Addendum upon written notice without cause.

Provider

BY:

Signature of Provider

Name: _____

Title: _____

Date: _____

Cabinet for Human Resources
Department for Medicaid Services

BY:

Signature of Authorized
Official or Designee

Name: _____

Title: _____

Date: _____

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____ to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;
2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement; misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

Signature, Authorized Agent of Billing Agency

Date: _____

Contact Name: _____

Telephone No.: _____

Signature, Representative of the
Department for Medicaid Services

Date: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

Agreement Between the
Kentucky Medical Assistance Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medical Assistance Program.

The _____ has
(Name of Billing Agency)

entered into a contract with _____
(Name of Provider)

_____, to submit claims via electronic media for
(Provider Number)
services provided to KMAP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;
2. To maintain a record of all claims submitted for payment for a period of at least five (5) years;
3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMAP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

Signature, Authorized Agent of Billing Agency

Date

Signature, Representative of the
Department for Medicaid Services

ADULT DAY HEALTH CARE SERVICES MANUAL

ADULT DAY HEALTH CARE PROCEDURE CODES

The Kentucky Medical Assistance Program locally assigned Health Care Financing Administration Common Procedure Coding System (HCPCS) codes for Adult Day Health Care Services are as follows:

The first digit is an X (left to right) and is a constant for the Home and Community Based Services Waiver Program.

The second digit is an R and refers to Adult Day Health Care Service.

The third digit identifies the specific adult day health care service provided:

- 0 Basic Daily Service
- 4 Physical Therapy Service
- 5 Occupational Therapy Service
- 6 Speech Therapy Service

The last two digits identify the primary procedure provided. Basic daily services and ancillary services MUST be entered on separate lines.

XR000 Basic Daily Service

Units of Service: $\frac{1}{2}$ day equals 1 unit
1 full day equals 2 units

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ADULT DAY HEALTH CARE SERVICES MANUAL

ADULT DAY HEALTH CARE PROCEDURE CODES

XR400-XR499 PHYSICAL THERAPY SERVICES

- XR400 Initial Evaluation of patient for Physical Therapy Program
- XR401 Patient Assessment for Physical Therapy Program through applying muscle, nerve, joint and functional ability tests
- XR402 Training and instructions for patient/family in setting up and following a Physical Therapy Program
- XR403 Follow-up visit to evaluate progress of therapy program established in #402
- XR404 Gait evaluation and training
- XR405 Therapeutic exercise program by therapist (including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, increased range of motion)
- XR406 Transfer Training
- XR407 Instructions in the care and use of wheelchairs, braces, crutches, canes, prosthesis and/or orthotic devices
- XR408 Breathing Exercises, Percussion/Postural Drainage/Vibration for Pulmonary Functioning
- XR409 Teaching compensatory technique to improve the level of independence in activities of daily living
- XR410 Other Physical Therapy visit (Identify in Item #15, Procedure/Supply Description column)
- XR411-XR499

Units of Service - A unit of service would be a patient encounter.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ADULT DAY HEALTH CARE SERVICES MANUAL

ADULT DAY HEALTH CARE PROCEDURE CODES

XR500-XR599 OCCUPATIONAL THERAPY

- XR500 Initial Evaluation of patient's level of function for Occupational Therapy Program
- XR501 Visit for training for better coordination, use of senses and perception
- XR502 Therapeutic exercise program by therapist (including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, increased range of motion)
- XR503 Instructions for patient and/or family in setting up and following an occupational therapy program
- XR504 Follow-up visit to evaluate progress of patient and/or family in following program set up in #503
- XR505 Teaching compensatory technique to improve the level of independence activities of daily living
- XR506 Designing and fitting of orthotic and self-help devices (i.e. hand splint for patient with rheumatoid arthritis)
- XR507 Other Occupational Therapy visit (Identify in Item #15, Procedure/Supply Description column)

XR508-XR599

Units of Service - A unit of service would be a patient encounter.

XR600-XR699 SPEECH THERAPY SERVICES

- XR600 Initial Evaluation of patient for Speech Therapy Program (Determines and recommends the appropriate speech and hearing service)
- XR601 Instructions for patient and/or family in setting up and following a Speech Therapy Program
- XR602 Followup visit to evaluate the progress of Speech Therapy Program set up in #601
- XR603 Visit to provide rehabilitative services for speech, hearing, and language disorders
- XR604 Miscellaneous Speech Therapy visit (Please identify in Item #15, Procedure/Supply Description column)

XR605-XR699

Units of Service - A unit of service would be a patient encounter.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

NEW FORM

APPENDIX VI

APPROVED OMB-0932-0008

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM										PICA					
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER		FOR PROGRAM IN ITEM 11			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)					
CITY		STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/>					CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code) ()			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVE FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom or INJURY (Accident or PREGNANCY(LMP)) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____					22. PRIOR AUTHORIZATION NUMBER					23. PRIOR AUTHORIZATION NUMBER					
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE															
25. FEDERAL TAX ID NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		
28. TOTAL CHARGE \$										29. AMOUNT PAID \$			30. BALANCE DUE \$		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse copy to this bill and are made a part thereof.										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		
SIGNED _____ DATE _____										PIN# _____			GRP# _____		

COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT
GENERAL MEDICAL

MAP-4 (REV. 2/88)
 EDS
 P.O. Box 2053
 Frankfort, Ky. 40602

1. PREVIOUS LAST NAME				2. FIRST NAME				3. MI		4. MEDICAL ASSISTANCE ID NUMBER					
5. CHECK BOX IF: 1) PATIENT WAS IN ANY KIND OF ACCIDENT, OR 2) EMERGENCY ANESTHESIA <input type="checkbox"/>				6. IF PATIENT HAS HEALTH INSURANCE, ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBERS						7. RECIPIENT DATE OF BIRTH MO DAY YR					
8. IF CLAIM REQUIRED A PRIOR AUTHORIZATION ENTER THE PRIOR AUTHORIZATION NUMBER HERE _____				9. INDICATE CATEGORY OF SERVICE				10. ENTER REFERRING PROVIDER'S MEDICAID NUMBER				11. IF SERVICES WERE PROVIDED AS A RESULT OF A EPSDT EXAM, REFERRAL CHECK BOX <input type="checkbox"/>			
40 <input type="checkbox"/> BIRTHING CENTERS 42 <input type="checkbox"/> CMHC 43 <input type="checkbox"/> FAMILY PLANNING 44 <input type="checkbox"/> HOME HEALTH				04 <input type="checkbox"/> RENAL CLINIC 05 <input type="checkbox"/> NURSE ANESTHETIST 06 <input type="checkbox"/> NURSE MIDWIFE 07 <input type="checkbox"/> AIS MR				81 <input type="checkbox"/> AUDIOLOGY 82 <input type="checkbox"/> HCS WAIVER 83 <input type="checkbox"/> ADULT DAY HEALTH 84 <input type="checkbox"/> OTHER (ENTER CODE)							
12. (1) FIRST DIAGNOSIS										DIAGNOSIS CODE					
12. (2) SECOND DIAGNOSIS										DIAGNOSIS CODE					
13. LINE NO.	14. DATE OF SERVICE MO DAY YR	15. PROCEDURE / SUPPLY DESCRIPTION	16. PROVIDER LICENSE NUMBER	17. PROCEDURE SUPPLY CODE	18. UNITS OF SERVICE	19. PLACE OF SERVICE NOTE (1)	20. SEE NOTE (2)	21. FAMILY PLANNING NOTE (3)	22. PROCEDURE CHARGE	23. PROFESSIONAL COMPONENT (O/P ONLY)					
01															
02															
03															
04															
05															
06															
07															
08															
09															
10															
NOTE (1) PLACE OF SERVICE CODES				7. (NH) NURSING HOME				C. (RTC) RESIDENTIAL				NOTE (2)			
1. (IH) INPATIENT HOSPITAL				8. (SNF) SKILLED NURSING FACILITY				D. (STF) SPECIALIZED TREATMENT FACILITY				ENTER DIAGNOSIS TREATED FROM BLOCK 12 "1" FIRST "2" SECOND			
2. (OH) OUTPATIENT HOSPITAL				9. AMBULANCE				E. (COR) COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY				TOTAL CLAIM CHARGE			
3. (OI) DOCTOR'S OFFICE				0. (OL) OTHER LOCATIONS				F. (KDC) INDEPENDENT KIDNEY DISEASE TREATMENT CENTER				LESS AMOUNT FROM HEALTH INSURANCE/ OTHER SOURCES			
4. (H) PATIENT'S HOME				A. (IL) INDEPENDENT LABORATORY								24			
5. DAY CARE FACILITY (PSV)				B. (ASC) AMBULATORY SURGICAL CENTER								25			
6. NIGHT CARE FACILITY (PSV)												NET CLAIM CHARGE			
26. PROFESSIONAL RENDERING SERVICE IF DIFFERENT FROM INVOICING PROVIDER (BLOCK 30) NAME										27. PROVIDER NUMBER		28. INVOICE DATE MO DAY YR			
29. PROVIDER CERTIFICATION AND SIGNATURE: This is to certify that the foregoing information is true, accurate, and complete and that any subsequent information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.															
30. PROVIDER NAME AND ADDRESS										31. PROVIDER NUMBER		32. INVOICE NUMBER			
33. NAME AND ADDRESS OF HOSPITAL										34. HOSPITAL PROVIDER NUMBER		35. CLINIC PROVIDER NUMBER			

AS OF 01/06/92

APPENDIX VII
Page 1

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

RA NUMBER 2 PROVIDER NAME
RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3834042135	9883324-552-580	123191-123191	50.00	2.00	0.00	48.00	365
01 PS 3	PROC-01234	QTY 5		123191-123191	30.00	0.00		30.00	61
02 PS 3	PROC 12345	QTY 5		123191-123191	20.00	2.00		18.00	365

CLAIMS PAID IN THIS CATEGORY: 1

TOTAL BILLED: 50.00

TOTAL PAID: 48.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX-REMITTANCE STATEMENT

AS OF 01/06/'92

PROVIDER NAME
PROVIDER NUMBER

RA NUMBER
RA SEQ NUMBER 2

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
023104	JONES R	4321712345	9838348-552-010	123191-123191	30.00	254
01 PS 6	PROCEDURE 11122	QTY 1		123191-123191	30.00	

CLAIMS DENIED IN THIS CATEGORY: 1 TOTAL BILLED: 30.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/92

PROVIDER NAME
PROVIDER NUMBER

RA NUMBER
RA SEQ NUMBER 2

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NAME	NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	TOTAL CHARGES	EOB
71384	JOHNSON P	2471340401	9883342-564-210	123191-123191	32.00	260
74632	MITCHELL J	4331740410	9883347-575-240	123191-123191	24.00	260

CLAIMS PENDING IN THIS CATEGORY: 2

TOTAL BILLED: 56.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/92

RA NUMBER
RA SEQ NUMBER 2
CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

PROVIDER NAME
PROVIDER NUMBER

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC. DATE	EOB
324789	SMITH	4838021143	9883324-552-060	123191-123191
				999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

CLAIMS PAYMENT SUMMARY

CURRENT PROCESSED YEAR-TO-DATE TOTAL	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
	2 36	48.00 1340.00	0.00 50.00	48.00 1290.00	0.00 0.00	48.00 1290.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 01/06/92

RA NUMBER
RA SEQ NUMBER 2

CLAIM TYPE: ADULT DAY HEALTH CARE SERVICES

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

PAID IN FULL BY MEDICAID
THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
ELIGIBILITY DETERMINATION IS BEING MADE
FEE ADJUSTED TO MAXIMUM ALLOWABLE
REQUIRED INFORMATION NOT PRESENT

061
254
260
365
999

NEW FORM
THIRD PARTY LIABILITY
LEAD FORM

APPENDIX VIII

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address : _____

Policy #: _____ Start Date: _____ End Date: _____

Date Filed with Carrier : _____

Provider Name : _____ Provider #: _____

Comments: _____

Signature: _____ Date: _____

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~Listed below are ICD-9-CM diagnosis codes which are most frequently utilized by long term care facilities. They are provided for your information and convenience in the coding of claims.~~

~~If additional diagnosis codes are needed/desired, please refer to the ICD-9-CM publication which can be purchased from the following:~~

~~ICD-9-CM Volume II
P.O. Box 991
Ann Arbor, Michigan 48106~~

~~7873 Abdominal Distention
6820 Abscess, Facial (cellulitis)
59389 Absence of Kidney
7564 Achondroplasia
3049 Addiction, Drug
99581 Adult Abuse
3079 Agitation
3039 Alcohol Addiction
9953 Allergies
3310 Alzheimer's Disease
7809 Amnesia (loss of memory)
9059 Amputation (late effect) any part
33520 Amyotrophic Lateral Sclerosis
ANEMIA-
2859 Anemia, NOS
2849 Aplastic
2851 Blood Loss, acute
2829 Hemolytic
2849 Hypoplastic
2809 Iron deficiency (microcytic)
 (hypochromic)
2810 Pernicious
2859 Secondary (Normocytic)
28260 Sickle Cell~~

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

ADULT DAY HEALTH CARE SERVICES MANUAL

ICD-9-CM DIAGNOSIS CODES

~~ANEURYSM~~

~~4429 Aneurysm, NOS~~
~~4414 Abdominal Aorta~~
~~4419 Aorta, NOS~~
~~74781 Brain~~
~~44281 Carotid Artery~~
~~4139 Angina Pectoris~~
~~7830 Anorexia~~
~~3071 Anorexia Nervosa~~
~~30002 Anxiety~~
~~7843 Aphasia (mutism)~~
~~436 Apoplexy (acute)~~
~~438 Apoplexy (late effects)~~

~~ARTERIOSCLEROSIS (ATHEROSCLEROSIS)~~

~~4400 Arteriosclerosis, Aorta~~
~~4292 Arteriosclerotic Cardiovascular disease (or accident) ASCVD~~
~~4370 Arteriosclerotic Cerebrovascular disease~~
~~4409 Arteriosclerosis, generalized GAS~~
~~4140 Arteriosclerotic heart disease ASHD~~
~~4409 Arteriosclerotic Vascular ASVD disease~~

~~ARTHRITIS~~

~~7169 Arthritis, Unspecified~~
~~7159 Degenerative, except spine~~
~~72190 Degenerative, spine~~
~~2740 Gouty~~
~~7159 Hypertrophic~~
~~7159 Osteoarthritis~~
~~7140 Rheumatoid, NOS RA~~
~~7110 Septic~~
~~4279 Arrhythmia, cardiac (or Bradycardia or Tachycardia)~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~7194 Arthralgia
73342 Aseptic Necrosis, femur
4939 Asthma
1919 Astrocytoma
7810 Athetosis
5964 Atonic Urinary Bladder
42731 Atrial Fibrillation (Auricular)
7282 Atrophy, arm
7919 Azotemia
3510 Bell's Palsy
600 Benign Prostate Hypertrophy BPH
BLEEDING (HEMORRHAGE)
5968 Bladder
431 Cerebral (Brain)
5789 Gastrointestinal GI
5998 Genito-Urinary GU
5789 Intestinal
6271 Post-Menopausal
5693 Rectal
430 Subarachnoid
6238 Vaginal
36901 Blindness, both eyes
36961 Blindness, one eye
3339 Body movement disorder
5609 Bowel Obstruction (intestinal)
BRAIN (CEREBRAL)
3312 Atrophy, senile
3319 Atrophy, not due to senility
8514 Brain Stem Contusion
3489 Brain Stem Damage
9319 Degeneration, NOS
3489 Disease
8540 Injury, late effect
3109 Syndrome, acute or chronic~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~2949 Syndrome with psychosis~~
~~2931 Trauma with psychosis~~
~~61172 Breast Mass~~
~~494 Bronchiectasis~~
~~BRONCHITIS~~
~~490 Bronchitis, NOS~~
~~4660 Acute~~
~~4939 Asthmatic~~
~~4912 Asthmatic (chronic)~~
~~4919 Chronic~~
~~BURNS~~
~~946 Specified Site~~
~~949 Unspecified Site~~
~~CANCER (NEOPLASM) CA~~
~~1940 Adrenal (Neuroblastoma)~~
~~1543 Anus~~
~~1732 Basal Cell of Ear~~
~~1910 Basal Ganglia~~
~~1539 Bowel/Intestine/Colon~~
~~1889 Bladder~~
~~1709 Bone, NOS~~
~~1919 Brain~~
~~1749 Breast~~
~~1629 Bronchiole~~
~~1809 Cervix~~
~~1539 Colon~~
~~1599 Digestive Tract~~
~~1820 Endometrium~~
~~1509 Esophagus~~
~~1950 Face~~
~~1560 Gallbladder~~
~~1539 Intestinal (large)~~
~~1952 Intra Abdominal~~
~~2398 Jaw, NOS~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~1890 Kidney, except pelvis
1891 Kidney pelvis
1619 Larynx, NOS
2081 Leukemia, chronic
2089 Leukemia, unspecified
1552 Liver
1629 Lung (or Bronchial)
2028 Lymphoma
1719 Lymph System
1602 Maxillary Sinus
1729 Melanoma
1991 Metastatic and unspecified site
1458 Mouth, parts unspecified
2030 Multiple Myeloma
2030 Myeloma
1950 Neck
1950 Nose
1830 Ovary
1579 Pancreas, NOS
1420 Parotid Gland
1874 Penis
185 Prostate
1541 Rectum
1734 Scalp
1533 Sigmoid
1739 Skin, NOS
1702 Spine
1519 Stomach, NOS
1490 Throat/Pharynx
1419 Tongue
1893 Urethra
179 Uterus, NOS
1610 Vocal Cords
1844 Vulva
6218 Calcified Uterine Fibroid~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~CARDIAC (HEART)~~

~~4275 Arrest
4279 Arrhythmia
42789 Bigeminy
4265 Bundle Branch Block
4293 Cardiomegaly
4254 Cardiomyopathy
4292 Cardiovascular Heart Disease CVHD
4299 Decompensation
4291 Degeneration
4299 Heart Disease (organic)
7852 Murmur
4290 Myocarditis
4239 Pericarditis
3669 Cataract, NOS
3499 Central Nervous System Disease~~

~~CEREBRAL (BRAIN)~~

~~4370 Arteriosclerosis CAS
3319 Atrophy
8518 Contusion
326 Damage (post Encephalitis)
3319 Degeneration
3483 Dysfunction (Encephalopathy)
4341 Embolism
4349 Infarction
4371 Ischemia
3488 Lesion
4340 Thrombosis
4349 Vascular Occlusion
3439 Cerebral Palsy CP~~

~~CEREBRAL VASCULAR~~

~~436 Accident (Acute) CVA
438 Accident (late effect)
4379 Disease CVD
4379 Ischemia (Insufficiency) CVI~~

~~E~~ CABINET FOR HUMAN RESOURCES
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~CELLUTIS~~

~~6829 Cellulitis, NOS~~
~~6823 Arm~~
~~6826 Hip~~
~~6826 Leg~~
~~78650 Chest Pain~~
~~5761 Cholangitis~~
~~57410 Cholecystitis with calculus~~
~~5751 Cholecystitis, NO calculus~~
~~(Chronic) (Gall Bladder Disease)~~
~~5750 Cholecystitis, acute~~
~~57400 Cholelithiasis with~~
~~acute cholecystitis~~
~~57420 Cholelithiasis, NOS~~
~~3109 Chronic Brain Syndrome CBS~~
~~2949 with Psychosis~~
~~496 Chronic Obstructive COPD~~
~~Pulmonary Disease~~
~~5715 Cirrhosis, liver~~
~~5589 Colitis, NOS~~
~~5589 Colitis, chronic~~
~~4462 Collagen Vascular Disease~~
~~V553 Colostomy~~
~~7800 Comatose (coma)~~
~~8509 Concussion, current~~
~~9070 Concussion, late effect~~
~~2982 Confusion~~
~~4280 Congestive Heart Failure CHF~~
~~514 Congestion, Pulmonary, chronic~~
~~37230 Conjunctivitis~~
~~5640 Constipation~~
~~71840 Contractures~~
~~CONTUSION (SPRAINS) (INJURY)~~
~~9239 Arm~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~8510 Brain,~~
~~8511 Brain (open wound)~~
~~9221 Chest Wall~~
~~92401 Hip (contusion)~~
~~9596 Hip (injury)~~
~~9229 Trunk~~
~~7803 Convulsions~~
~~4149 Coronary Artery Disease~~
~~4118 Coronary Insufficiency~~
~~4148 Coronary Insufficiency (old)~~
~~4169 Cor Pulmonale~~
~~243 Cretinism (congenital hypothyroidism)~~
~~5559 Crohn's Disease~~
~~2770 Cystic Fibrosis~~
~~5959 Cystitis~~
~~3899 Deafness~~
~~3897 Deaf-mutism~~
~~797 Debility~~
~~7070 Decubitis Ulcer~~
~~7599 Deformity, congenital~~
~~(congenital anomaly)~~
~~3319 Degenerative Brain Disease~~
~~722 Degenerative Disc Disease~~
~~7159 Degenerative Joint Disease DJD~~
~~2765 Dehydration~~
~~2988 Dementia, NOS (Reactive Psychosis)~~
~~2953 Dementia, Paranoid~~
~~29010 Dementia, Pre-Senile~~
~~2900 Dementia, Senile~~
~~DEPRESSION~~
~~311 Depression, NOS~~
~~2963 Agitated, recurrent~~
~~3004 Anxiety~~
~~2962 Psychotic~~

~~CABINET FOR HUMAN RESOURCES—
DEPARTMENT FOR MEDICAID SERVICES—~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL—~~

~~ICD-9-CM DIAGNOSIS CODES—~~

~~3004 Reactive
29021 Senile
6929 Dermatitis
2500 Diabetes Mellitus DM
2535 Diabetes Insipidus
9952 Digitoxin Adverse Effect (Intoxication)
 Dilantin Intoxication
3442 Diplegia
83500 Displacement, femur
7222 Displacement, lumbar disc
7873 Distention (abdominal)
56210 Diverticulitis of Colon
56200 Diverticulitis of Duodenum
5306 Diverticulitis of Esophagus
56211 Diverticulosis of Colon
7580 Down's Syndrome
5368 Dyspepsia (Stomach Function Disease)
7872 Dysphagia
7845 Dysphasia
78609 Dyspnea
7881 Dysuria
7823 Edema, NOS
5184 Edema, Pulmonary, acute
514 Edema, Pulmonary, chronic
4280 Edema due to heart disease
2769 Electrolyte disorder
444 Embolism, NOS
4151 Embolism, Pulmonary
44422 Embolism, lower extremity
4928 Emphysema
2599 Endocrine Dysfunction
3459 Epilepsy, NOS
7847 Epistaxis
5301 Esophagitis~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~261 Failure to thrive (Marasmus)~~
~~56039 Fecal impaction~~
~~6191 Fistula Recto-Vaginal~~
~~8074 Flail Chest~~
~~FRACTURES FX~~
~~8248 Ankle~~
~~8180 Arm~~
~~81000 Clavical~~
~~82100 Femur~~
~~9053 Femur (late effect)~~
~~82381 Fibula~~
~~81380 Forearm~~
~~81220 Humerus~~
~~8208 Hip, closed~~
~~8209 Hip, open~~
~~9053 Hip, late effect~~
~~(or with prosthesis)~~
~~82021 Intertrochanteric, closed~~
~~82031 Intertrochanteric, open~~
~~8220 Knee~~
~~8270 Leg~~
~~82380 Lower Leg~~
~~8054 Lumbar Vertebrae~~
~~8088 Pelvis~~
~~8070 Ribs~~
~~8030 Skull~~
~~8052 Spine, Thoracic~~
~~8058 Spine (vertebrae)~~
~~82380 Tibia~~
~~8290 Unspecified~~
~~7331 Vertebral Collapse (Path. FX)~~
~~81400 Wrist~~
~~3340 Friedreichs ataxia~~
~~9913 Frostbite~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~5649 Functional Bowel Disease~~
~~1179 Fungus Infection~~
~~7812 Gait Ataxia~~
~~5751 Gall Bladder Disease~~
~~3301 Gangliodosis~~
~~7854 Gangrene, NOS~~
~~4402 Gangrene, arteriosclerotic~~
~~2507 Gangrene, diabetic~~
~~5355 Gastritis~~
~~5589 Gastro-Enteritis (Diarrhea)~~
~~3659 Glaucoma~~
~~2419 Goiter, Non-toxic~~
~~2420 Goiter, Toxic~~
~~3570 Guillain-Barre Syndrome~~
~~7810 Hammond's Disease (Athetosis)~~
~~8540 Head Injury~~
~~4269 Heart Block~~
~~4292 Heart Disease, NOS~~
~~39890 Heart Disease, Rheumatic~~
~~3429 Hemiplegia~~
~~3429 Hemiparesis~~
~~HEMATOMA~~
~~4320 Epidural (Brain)~~
~~8522 Subdural (Brain)~~
~~8518 Intracranial~~
~~5997 Hematuria~~
~~7863 Hymoptysis~~
~~Hemorrhage see bleeding~~
~~4556 Hemorrhoids~~
~~5722 Hepatic Coma~~
~~7891 Hepatomegaly~~
~~5733 Hepatitis, NOS~~
~~0709 Hepatitis, Viral~~
~~HERNIA~~
~~5539 Hernia, NOS~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~55320 Abdominal
5533 Hiatal (esophageal)
 (diaphragmatic)
5531 Umbilical
5509 Inguinal, uncomplicated
5500 Inguinal, complicated
0539 Herpes Zoster (Shingles)
2019 Hodgkins Disease
3314 Hydrocephalus, acquired
7423 Hydrocephalus, congenital
3334 Huntington's Chorea
4019 Hypertension HBP
4010 Hypertension, Malignant
40290 Hypertensive Cardio- HCVD
 vascular disease
402 Hypertensive heart disease
2429 Hyperthyroidism (Thyrotoxicosis)
2512 Hypoglycemia
2768 Hypokalemia
2761 Hyponatremia
2449 Hypothyroidism (Myxedema)
3481 Hypoxic Encephalopathy
9916 Hypothermia
2765 Hypovolemia
30010 Hysteria
56039 Impaction, fecal
5368 Indigestion (stomach function disease)
 INCONTINENCE
7876 Feces (stool)
7883 Urine (neurogenic bladder)
 INFARCTION
4349 Cerebral
4109 Myocardial, acute
412 Myocardial, old~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~INJURY~~

~~9239 Arm~~
~~8540 Brain~~
~~8540 Head~~
~~9596 Hip/Thigh~~
~~9599 Injury - Not otherwise specified~~
~~8678 Pelvis~~
~~9560 Sciatic Nerve~~
~~9592 Shoulder~~
~~9529 Spinal~~

~~INSUFFICIENCY~~

~~5571 Bowel~~
~~4241 Aortic Stenosis~~
~~4292 Cardiovascular~~
~~4331 Carotid Stenosis~~
~~4379 Cerebrovascular~~
~~4148 Coronary~~
~~5738 Liver (Hepatic)~~
~~4439 Peripheral vascular (PVI)~~
~~5939 Renal~~
~~78609 Respiratory~~
~~45981 Venous~~
~~5609 Intestinal Obstruction~~
~~4599 Ischemia~~

~~ISCHEMIC HEART DISEASE~~

~~4109 Ischemic Heart Disease, acute~~
~~4149 Ischemic Heart Disease, chronic~~
~~7199 Joint disease, NOS~~
~~5909 Kidney Infection~~
~~5920 Kidney Stone (calculus)~~
~~2911 Korsakoff's Syndrome (alcoholic)~~
~~73710 Kyphosis~~
~~73730 Kyphoscoliosis~~
~~38630 Labyrinthitis~~

~~CABINET FOR HUMAN RESOURCES—
DEPARTMENT FOR MEDICAID SERVICES—~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9 CM DIAGNOSIS CODES~~

~~37716 Leber's Disease—
2089 Leukemia—
5739 Liver Disease, except Hypertrophy—
7891 Liver Hypertrophy—
73720 Lordosis—
5188 Lung Disease, Chronic—
6954 Lupus Erythematosus—
7856 Lymph Adenopathy—
2041 Lymphatic Leukemia—
4571 Lymph Edema—
2001 Lymphosarcoma—
2639 Malnutrition—
5647 Megacolon—
38600 Meniere Disease (syndrome)—
3229 Meningitis—
MENTAL RETARDATION MR—
319 Mental Retardation, unspecified—
317 Mild—
3180 Moderate—
3182 Profound—
3181 Severe—
3469 Migraine—
7580 Mongoloidism—
3352 Motor Neuron Disease—
1739 Multiple Basal Cell Carcinoma—
340 Multiple Sclerosis MS—
7843 Mute—
3591 Muscular Dystrophy MD—
3580 Myasthenia Gravis—
2030 Myeloma—
MYOCARDIAL INFARCTION MI—
4109 Acute—
412 Old—
3005 Neurasthenia—~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~34461 Neurogenic Bladder (atonic)~~
~~5809 Nephritis, acute~~
~~5829 Nephritis, chronic~~
~~5839 Nephritis, NOS~~
~~7992 Nervousness (tension)~~
~~3009 Neurosis (or emotional disorder)~~
~~2780 Obesity~~
~~496 Obstructive Lung Disease~~
~~OBSTRUCTION~~
~~5960 Bladder Neck~~
~~5609 Bowel~~
~~5762 Common Bile Duct~~
~~5768 Jaundice~~
~~5996 Urinary Tract Obstruction~~
~~60490 Orchitis (epidymitis)~~
~~3489 Organic Brain Disease~~
~~3109 Organic Brain Syndrome~~
~~2949 Organic Syndrome, with psychosis~~
~~7159 Osteoarthritis~~
~~7302 Osteomyelitis~~
~~73300 Osteoporosis~~
~~PAIN~~
~~7890 Abdominal~~
~~7242 Back, low (lumbago)~~
~~78650 Chest~~
~~71945 Hip~~
~~7295 Leg~~
~~V450 Pacemaker~~
~~7310 Pagets disease, bone~~
~~5771 Pancreatitis (chronic)~~
~~PARALYSIS (Paresis)~~
~~3449 Paralysis, NOS~~
~~3320 Agitans~~
~~5965 Bladder~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~5194 Diaphragm~~
~~3429 Hemiplegia~~
~~5601 Ileus (bowel)~~
~~3445 Monoplegia~~
~~3441 Paraplegia~~
~~3440 Quadriplegia~~
~~3449 Spastic~~
~~3568 Supranuclear~~
~~332 Parkinsonism~~
~~3579 Peripheral Neuropathy~~
~~4439 Peripheral Vascular Disease PVI~~
~~2810 Pernicious Anemia~~
~~3553 Peroneal Nerve Palsy~~
~~3019 Personality Disorder~~
~~4519 Phlebitis~~
~~4512 Phlebitis, legs~~
~~5119 Pleural Effusion~~
~~505 Pneumoconiosis~~
~~PNEUMONIA~~
~~486 Pneumonia, NOS~~
~~507 Aspiration~~
~~485 Bronchopneumonia, NOS~~
~~481 Pneumococcal~~
~~4829 Other Bacterial~~
~~5128 Pneumothorax~~
~~138 Polio, late effect~~
~~V660 Post-op follow-up~~
~~5691 Prolapsed Rectum~~
~~6181 Prolapsed Uterus~~
~~6961 Psoriasis~~
~~514 Pulmonary Congestion~~
~~5184 Pulmonary Edema, acute~~
~~514 Pulmonary Edema, acute with~~
~~ventricular failure~~

~~CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~515 Pulmonary Fibrosis~~
~~5183 Pulmonary Infiltrate~~
~~6029 Prostate Disease~~
~~600 Prostatic Hyperplasia, benign BPH~~
~~6011 Prostatitis, chronic~~
~~3009 Psychoneurosis~~
~~PSYCHOSIS~~
~~2989 Psychosis, NOS~~
~~2919 Alcoholic~~
~~29040 Associated with CAS~~
~~2940 Korsakov's, or Korsakoff's~~
~~29680 Manic Depressive~~
~~29381 Organic Delusional Syndrome~~
~~2979 Paranoid~~
~~29010 Pre-senile~~
~~59000 Pyelonephritis, chronic~~
~~59080 Pyelonephritis, NOS~~
~~53781 Pylorospasm~~
~~3440 Quadriplegia~~
~~5829 Renal Disease~~
~~585 Renal Failure, chronic~~
~~5920 Renal/Urethral Stone (calculus)~~
~~7991 Respiratory Failure, Distress~~
~~39890 Rheumatic Heart Disease~~
~~2959 Schizophrenia, NOS~~
~~4400 Sclerosis, Aorta~~
~~7101 Scleroderma~~
~~7101 Sclerosis, Progressive, Systemic~~
~~7803 Seizures (convulsions)~~
~~2900 Senile Dementia (senile brain syndrome)~~
~~29020 Senile Psychosis~~
~~797 Senility (debility)~~
~~0389 Septicemia~~
~~0539 Shingles, NOS~~
~~42781 Sick Sinus Syndrome SSS~~

~~CABINET FOR HUMAN RESOURCES—
DEPARTMENT FOR MEDICAID SERVICES—~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL—~~

~~ICD-9-CM DIAGNOSIS CODES—~~

~~42781 Sinus Disorder (heart)—
 7099 Skin Disease—
 5641 Spastic Colon—
 7200 Spondylitis (ankylosing)—
 0381 Staphylococcal Infection—
 4541 Stasis Dermatitis—
 7235 Stiff Neck (torticollis)—
 STRICTURE—
 4241 Aortic Valve—
 5303 Esophageal—
 5989 Urethral—
 4592 Venous—
 436 Stroke, acute CVA—
 438 Stroke, old—
 4660 Surgical aftercare—
 7802 Syncope—
 0949 Syphilis of Central Lues—
 Nervous System—
 0971 Syphilis, latent—
 7813 Tardive Dyskinesia—
 2875 Thrombocytopenia—
 4519 Thrombophlebitis, NOS—
 4512 Thrombophlebitis, leg (or phlebitis)—
 3501 Tic Douloureux—
 THROMBOSIS—
 4340 Cerebral—
 4109 Coronary—
 4538 Leg—
 4151 Pulmonary—
 4539 Unspecified—
 0419 Toxic Shock Syndrome—
 4359 Transient Ischemic Attack TIA—
 0119 Tuberculosis, pulmonary TB—~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~TUMOR~~

~~2396 Tumor, NOS~~
~~2375 Tumor (uncertain behavior)~~
~~7893 Abdominal Mass~~
~~2394 Bladder~~
~~2396 Brain, NOS~~
~~61172 Breast Mass~~
~~2357 Bronchiadenoma~~
~~2390 Colon~~
~~2390 Esophageal Neoplasm~~
~~2189 Fibroid Uterine~~
~~2252 Meningioma (benign)~~
~~7893 Retro Peritoneal Mass~~

~~ULCERS~~

~~37000 Corneal~~
~~7070 Decubitus~~
~~5329 Duodenal~~
~~5302 Esophagus~~
~~5319 Gastric (stomach)~~
~~7071 Lower extremity (leg)~~
~~5339 Peptic~~
~~56941 Rectal~~
~~7079 Skin, except decubitus~~
~~or leg~~
~~4540 Stasis~~
~~4659 Upper Respiratory URI~~
~~586 Uremia~~
~~7882 Urinary Retention~~
~~5990 Urinary Tract Infection (pyuria) UTI~~
~~4599 Vascular Insufficiency~~
~~4549 Varicose Veins~~
~~4540 Varicose Ulcers~~
~~7804 Vertigo (dizziness)~~
~~7870 Vomiting (nausea)~~

~~CABINET FOR HUMAN RESOURCES~~
~~DEPARTMENT FOR MEDICAID SERVICES~~

~~ADULT DAY HEALTH CARE SERVICES MANUAL~~

~~ICD-9-CM DIAGNOSIS CODES~~

~~2377 Von Recklinghausen's Disease~~
~~7807 Weakness~~
~~WOUND~~
~~8901 Open, hip/thigh (complicated)~~
~~8900 Open, hip/thigh (uncomplicated)~~
~~8730 Gunshot, head~~
~~OSTOMY~~
~~V441 Gastrostomy~~
~~V442 Ileostomy~~
~~V445 Cystostomy~~
~~V440 Tracheostomy~~
~~V446 Urethrostomy~~

P.O. Box 2009
Frankfort, Ky. 40602

Please remit both
copies of the Inquiry
Form to EDS.

1. Provider Number		3. Recipient Name (first, last)	
2. Provider Name and Address		4. Medical Assistance Number	
5. Billed Amount		6. Claim Service Date	
		7. RA Date	
9. Provider's Message		8. Internal Control Number	

10. _____
Signature Date

Dear Provider:

- _____ This claim has been resubmitted for possible payment.
- _____ EDS can find no record of receipt of this claim. Please resubmit.
- _____ This claim paid on _____ in the amount of _____
- _____ We do not understand the nature of your inquiry. Please clarify.
- _____ EDS can find no record of receipt of this claim in the last 12 months.
- _____ This claim was paid according to Medicaid guidelines.
- _____ This claim was denied on _____ for EOB code _____
- _____ Aged claim. Payment may not be made for services over 12 months old without proof that the claim was received by EDS within one year of the date of service; and if the claim rejects, you must show timely receipt by EDS within 12 months of that rejection date. Claims must be received by EDS every 12 months to be considered for payment.

Other: _____

APPENDIX X

1. Original Internal Control Number (I.C.N.)

2. Recipient Name

4. Provider Name/Number/Address

6. To Date Service

8. Paid Amt.	
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9. R.A. Data

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

13. Date

EDSF USE ONLY---DO NOT WRITE BELOW THIS LINE

New Data:

Previous Data:

Field/Line:

New Data:

Previous Data:

Other Actions/Remarks:

MAIL TO: EDS
P.O. BOX 2009
FRANKFORT, KY 40602

CASH REFUND DOCUMENTATION

Contact Name _____ Phone: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:428

Incorporation by Reference of the
Adult Day Health Care Manual

Summary of Incorporated Material

May 1992

- 1) The Adult Day Health Care Services Manual is used by center staff and participating providers of the Medicaid Program. This manual is being amended to reflect any significant policy changes which have been promulgated and approved in the appropriate administrative regulation, and to show any minor clarifications of policy or procedure which has been made.
- 2) 106 pages are being amended by the proposed regulation. The changes are listed below.
- 3) The Table of Contents is being amended to add, delete, and change headings to reflect the correct sections and page contents. These changes have no major impact on policy.
- 4) The manual has been changed throughout to reflect the Medicaid Program or Kentucky Medicaid instead of KMAP, or Medical Assistance Program. These changes have no impact on policy. The pages with changes are cover page, Table of Contents, pages 1.1, 2.1 - 2.8, 3.1, 3.2, 3.4, 3.6 - 3.8, 4.1, 4.5, 5.1, 6.1, 6.3, 7.1, 7.3, 8.1, and 9.4 - 9.5.
- 5) The manual has been changed to reflect the new telephone numbers for Electronic Data Systems on the following pages: 1.1, 6.4, 9.2, and 9.4. This has no impact on policy.
- 6) The section of electronic media claims was deleted from page 1.2 because it has been relocated on page 7.9 in the manual. This has no impact on policy.
- 7) References to patients throughout the manual have been changed to recipients in order to be consistent. The pages with this change are 3.5, 4.1, 4.2, 4.3, and 4.4. This has no impact on policy.

- 8) The section on medical records has been deleted from 2.8 because it has been relocated on page 3.10 in the manual. This has no impact on policy.
- 9) The section on timely submission of claims has been moved from page 2.8 to page 7.7, as it was felt this was a more appropriate location in the manual. It was reworded for additional clarification. This has no impact on policy.
- 10) The section entitled "Conditions of Participation" has been revised to more clearly describe the procedures an agency shall follow before participating with Medicaid. This does not represent a change in policy but is a clarification. Refer to page 3.1.
- 11) The section entitled "Provision of Adult Day Health Care" has been totally revised to include additional information about the process for being admitted to the HCB Waiver Program and the process for the ongoing reevaluation. This does not reflect a change in policy but is included for clarification. Refer to pages 3.3 - 3.4.
- 12) A new section on cash refund documentation procedures has been included in the manual. This represents a clarification of procedures. Refer to pages 9.8 - 9.10.
- 13) The change of ownership section has been changed to also state additional procedures to be followed when a provider has a change in ownership. This does not represent a change in policy but is included for procedural clarification. Refer to page 3.8.
- 14) Additional information has been included in the manual regarding third party liability. This does not represent a change in policy but is included for procedural clarification. Refer to page 6.3.
- 15) The billing procedures have been changed as the billing form has been changed to HCFA-1500 (Rev. 12/90). Please refer to pages 7.1 - 7.7.
- 16) Page 9.2 of the manual has been revised to show correct procedures for submitting adjusted claims and refunds. This does not represent a change in policy, only procedures.
- 17) Appendix I has been updated to reflect the current programs available through Medicaid. Refer to Appendix I, page 1 through page 10.

- 18) Appendix II, page 1, has been revised to remove the refugee resettlement programs as an eligibility program under the Department for Social Insurance, as it is no longer a covered program. This represents a change in eligibility programs policy.
- 19) The Manual Appendix Section has been updated with the most current revisions of the following forms: Provider Information Form, MAP-344 (Rev. 3/91); Provider Agreement Electronic Media Addendum, MAP-380 (Rev. 4/90); Agreement Between the Kentucky Medicaid Program and Electronic Media Billing Agency, MAP-246 (Rev. 4/91).
- 20) The Manual Appendix Section has been updated to include the following new forms: Certification of Lobbying, MAP-343A (Rev. 11/91); Health Insurance Claim Form, HCFA-1500 (Rev. 12/90); Third Party Liability Lead Form (Rev. 7/91); and Cash Refund Documentation Form. The MAP-4 form was deleted as it is no longer used.